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CONTENTS

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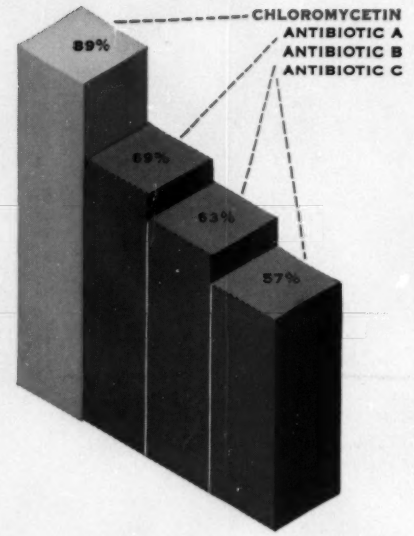

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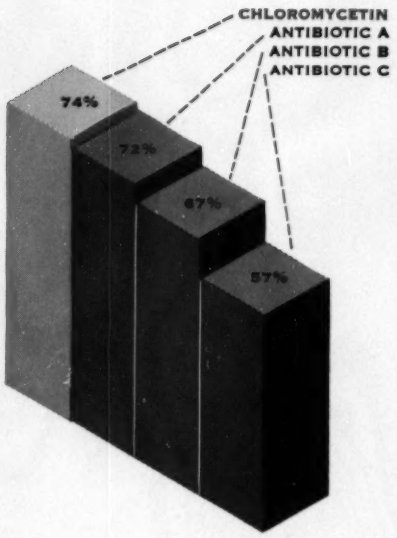

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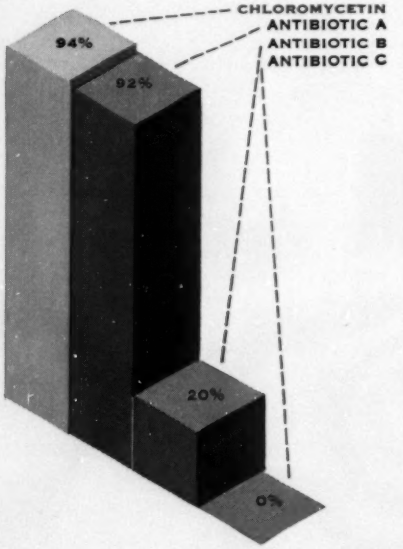

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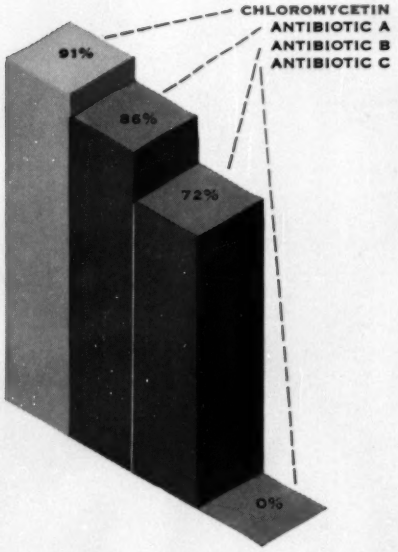

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References (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955. (2) Austrian, R.: *New York J. Med.* 55:2475 (Sept. 1) 1955. (3) Murphy, F. D., & Waisbren, B. A., *in* Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (4) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (7) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159 (Apr. 15) 1955.

*This graph is adapted from Altemeier, Culbertson, Sherman, Cole, Elstun, & Fultz.[1]

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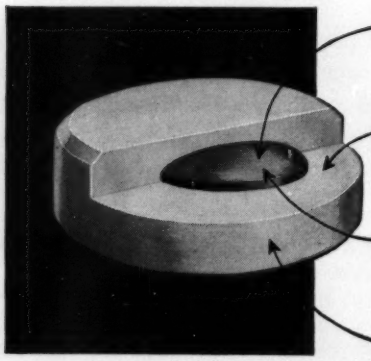

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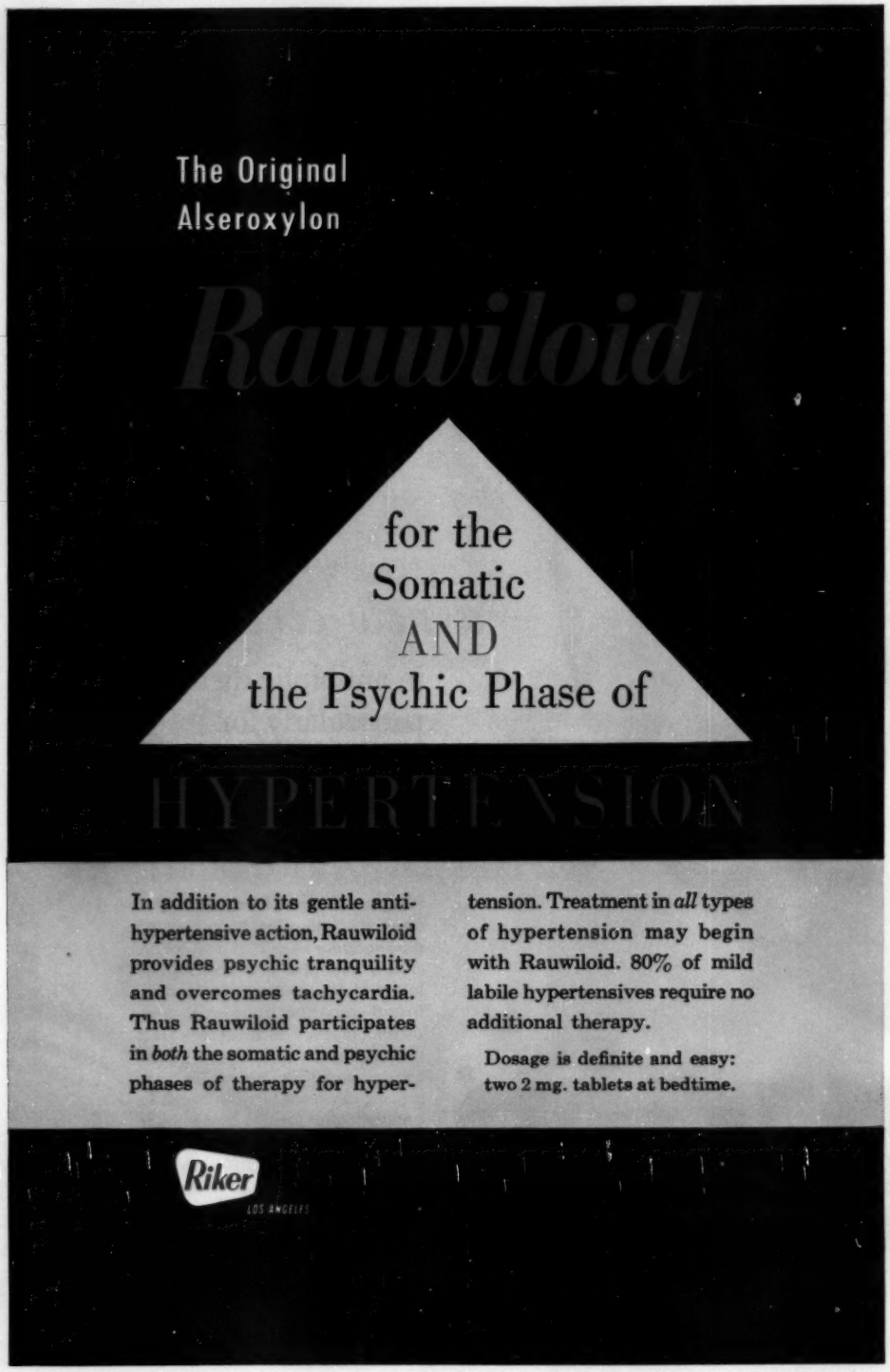
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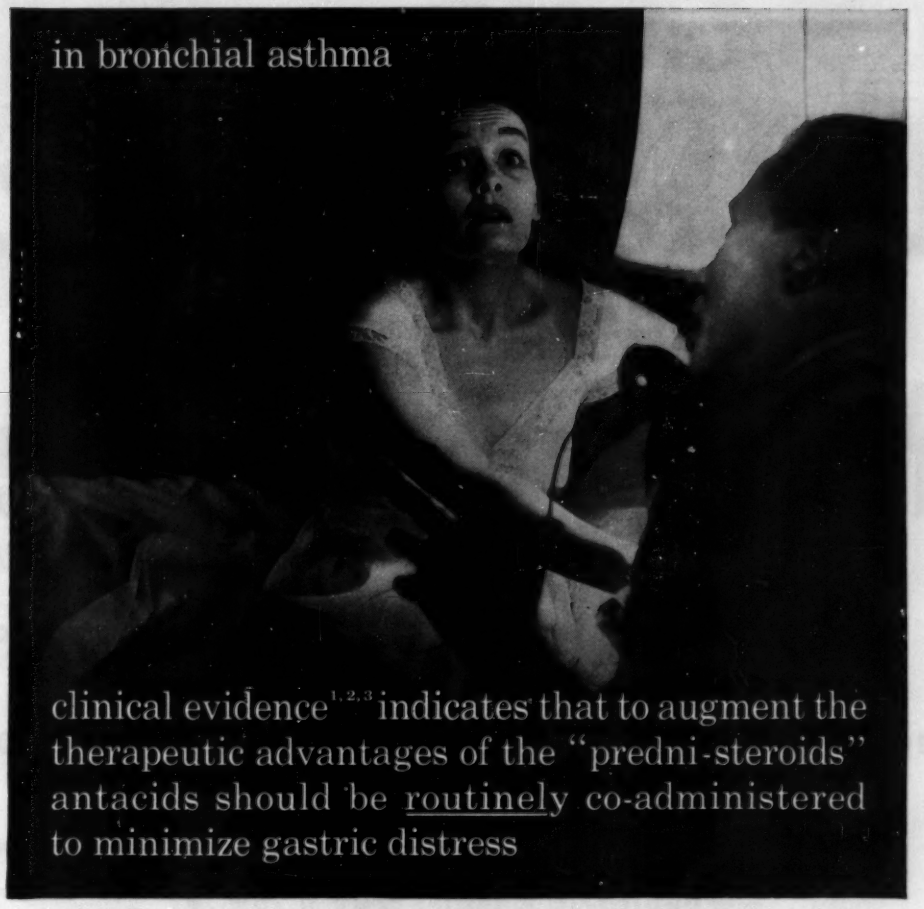

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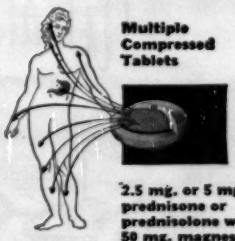

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References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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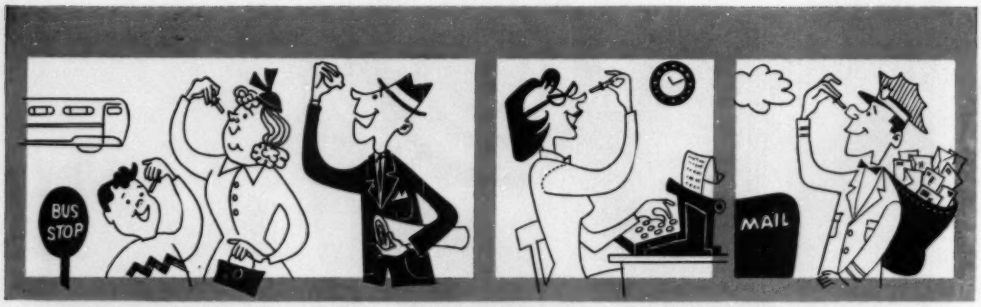

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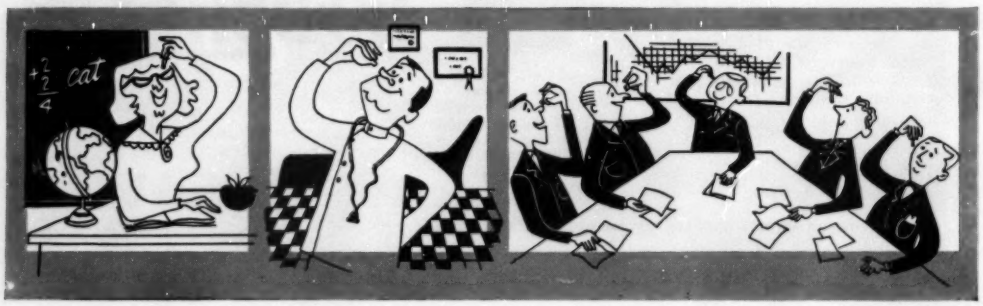

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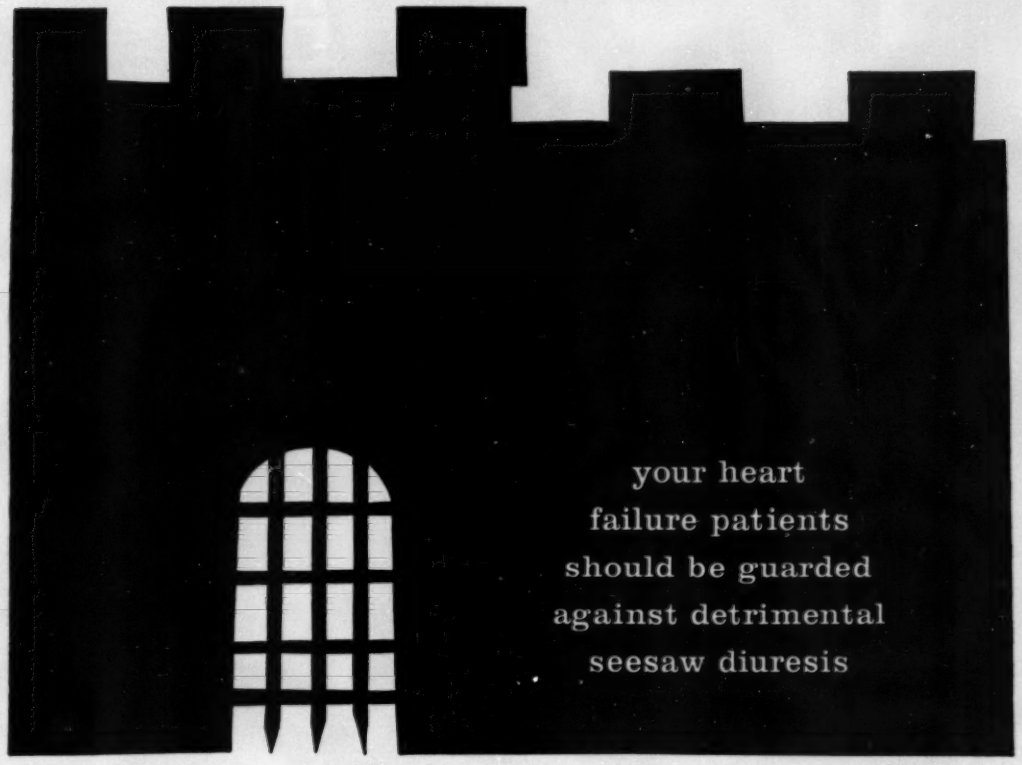

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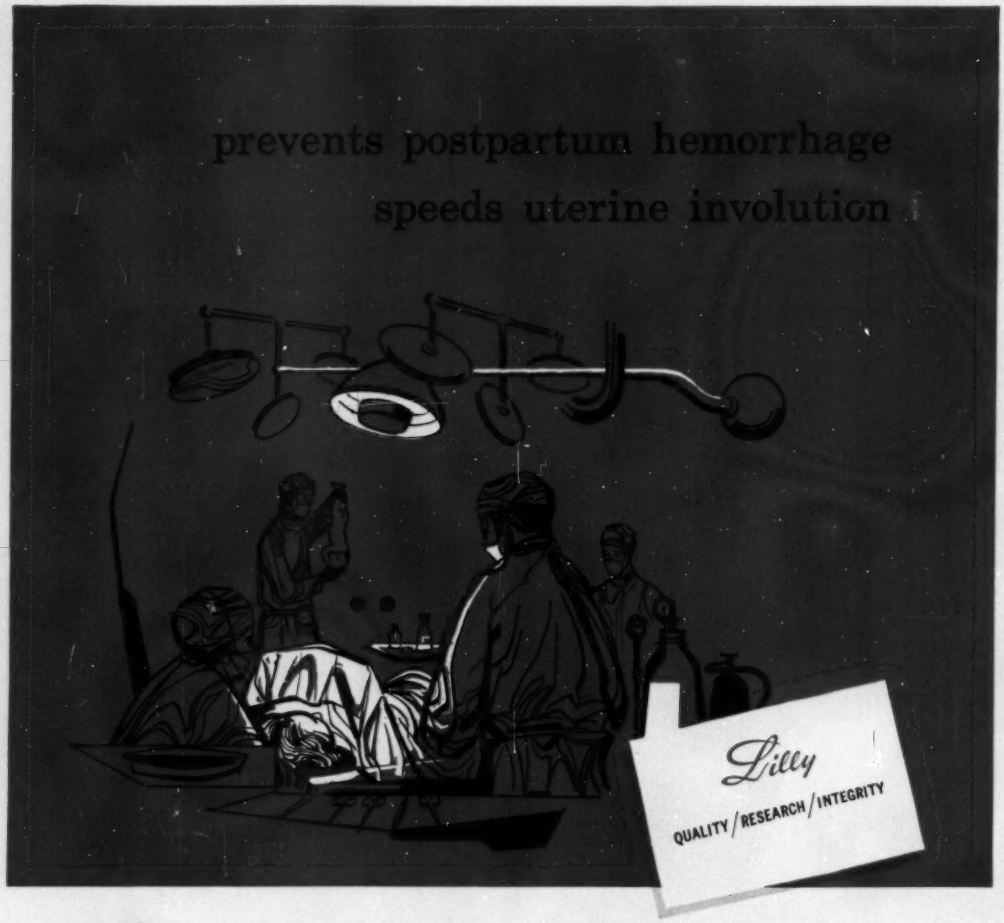

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THE PHYSICIAN AND THE PATIENT*

GLENN M. VANVALKENBURGH, M.D.

Many books, short stories and articles about the horse and buggy doctor have been published in past years. Most of them tell of the trials, hardships and triumphs of an early physician either in America or some other country. These stories, biographies or autobiographies, are full of incidents regarding a particular physician and his patients.

Frequently, I find incidents which I have experienced almost identically and, as I read, I can apply different names to the people about whom they are written and place them in my own memory. Perhaps I remember a dark and stormy night at some isolated farmhouse which I had reached over an uncertain, muddy road and where I worked by kerosene lamplight. Or it could have been in a brilliantly lighted city hospital with all the modern facilities available. Again, it may have occurred in my office. Wherever it was, there was the physician-patient relationship of which I, as a physician, am proud to be a part.

The other part or person involved is the patient. He also remembers the visit of the physician or a trip to the office. He recalls the familiar black bag, or the smell of antiseptics which permeated the room as he sat waiting his turn to see the doctor.

There are varied emotions present in the patient's approach to the physician. The small boy suspects that all may not be too fair when parent, nurse and doctor descend on him to treat a minor wound or inoculate him, telling him all the while, "It won't hurt." Is it any wonder that when the time comes for the next treatment he has to be cajoled or propelled into the physician's office? There is the patient who has a severe pain in some part of his anatomy and is seeking relief, fully convinced that he has one of the most dreadful and incurable ailments known. Some patients are apprehensive and tense and their complaints are vague. They have tried all the home remedies and "curbstone" advice before they seek professional treatment. Thank goodness, there are also those patients who come with the conviction that all will be well after they have seen the doctor.

People are individuals and each has his own likes, dislikes and reactions to situations and to other people, including his physician. Personalities are as different as faces and their general physical appearance.

In the days of the horse and buggy doctor, people lived at a slower pace than they do today. That was as true of the patient as it was of the doctor. Even in the early days of my practice there was a certain degree of leisurely life which did not match the hustle and impatience of today's pace. During that period there was usually sufficient time for a young physician to get acquainted with the patient's problems and conflicts which had a bearing on the diagnosis of the complaint at hand.

It is in this early period of his professional career that the young physician, inspired by his little tried textbook knowledge, frequently is confronted with a group of symptoms which are atypical and a diagnosis is baffling. In such instances he may wish for the assistance and protective supervision which he had in the hospital during his recent residency. It is, also, during this time, that a physician is made more acutely aware of the effort which he must put forth to gain the confidence of his patient. The physician needs to use kindness, sympathy, gentleness and to be a good listener to get such confidence. Such confidence and faith are essential for the comfort, peace of mind and full recovery of the patient.

Recently a woman came into my office with her husband and stated, "My husband has been going from one doctor to another

* Presidential Address delivered to the Medical Society of Delaware, September 13, 1956.

and doing what nearly everyone has suggested that he do, but if he just could find someone in whom he has confidence and follow his directions long enough, I believe he would be all right."

A patient comes to the physician because he is in distress of one kind or another, from headaches to fractures. He comes for relief of this distress and, as a physician trained in general practice or in any of the medical specialties, it is his duty to supply whatever means he can find to give such relief. In consultation it is necessary for the physician to observe the patient closely in order to evaluate the symptoms of which he complains.

One of my professors at medical school was a keen diagnostician who prided himself on his diagnosis by observation alone, to be confirmed by examination and laboratory tests later. He would send one member of the class to the door of a ward to see a patient in the second or third bed from the door for a thirty second period of observation. The student reported to him what he had seen. Several such trips were necessary before he was satisfied as to the findings though he had been able to see these same objective symptoms and to evaluate them quickly. This experienced physician was teaching us observation and how to place what we saw in the proper perspective.

Few physicians would want to rely on such methods for accurate diagnosis but all are keenly aware of outward appearance, attitude and mood of the patient as he comes to them for care. The weary housewife; the worried executive or office worker; the restless or lackadaisical school child; and the stooped, elderly person all have some readily observable signs which are clues to the physician in arriving at a diagnosis. The way they walk, the way they sit down, the expression of pain or anxiety on their faces or the tones of their voices are all signs which are observed and evaluated in connection with the subjective symptoms.

The history of the patient may have been taken by the office nurse but it is never complete without the added information derived by the physician from the patient himself. If he is allowed to talk freely with sympathetic, professional guidance both the patient and physician can expect to gain much in their mutual relationship.

The physician will be able to fit the symptoms, both objectively and subjectively, to the patient as related to his personal environment. Such careful listening and examination takes time for both people. The patient may be in less hurry than the doctor and thus may take up more than the allotted time to tell of his complaints. This can be exasperating to the physician because he knows that he has other appointments and that in his reception room are waiting several people who are anxious to return to their own duties. The doctor also has to try to maintain a schedule besides his office hours which includes hospital rounds and house visits, to say nothing of emergencies. Such pressures are real problems for both physician and patient. Each individual is guilty of thinking of the disruption of his own plans for the day. Everyone is affected by the tensions within himself and the pressures around him.

Other sources of misunderstanding between patient and physician are so-called "health" articles in national magazines. Recently, nearly every popular magazine has contained at least one article on a medical or pseudo-medical subject. These articles generally are written by a non-medical author and are read avidly by the general public. They usually concern a new drug and its uses, or they may criticize the medical profession and the high costs of medical care. Some of them are good but others are quite misleading. All are read by patients who hope to gain more knowledge about themselves and their own physical and emotional problems. Everyone is interested in himself and in living a long, happy life as free of pain or illness as possible. Because of this universal interest, physicians are frequently asked about the contents of these articles. They are asked why such and such a medication about which the patient has read would not be just the thing for him or a friend or relative. Of course, most of the articles fail to impress the reader with the fact that there are definite indications and contraindications for the use of these medications even

after an accurate diagnosis has been made.

The medical profession and allied professions have succeeded in lengthening the life span of the average American by many years in the past half century. Preventive medicine, improved sanitary conditions, better nutrition, vaccines, improved techniques of surgery and anesthesia, and new drugs have aided in lengthening the life span. Some diseases have been almost eradicated and others have been brought under control. Men coming out of medical school have never seen a case of smallpox, typhoid fever, diphtheria, or even lobar pneumonia, as we knew it a few years ago.

Antibiotics, hormones, stereoids, and other new drugs have done much for patient and physician alike. Research laboratories are continuously working on projects to increase knowledge of diseases and their causes. New and more efficient medications to prevent or treat diseases are constantly coming from our laboratories.

With this intense research activity and numerous discoveries which have been made to alleviate physical and mental suffering, the fact remains that patient and physician meet as individuals. The patient's confidence in his physician is necessary for a proper history, examination and continuation of the prescribed treatment. This is true whether at a free clinic or in the office of the specialist. It is an essential factor in patient-physician relationship for the general-practitioner, internist, surgeon or psychiatrist. He is expected to merit this confidence and respect. He is a public servant but must be an outstanding citizen. His personal behavior should be above reproach and it is necessary that he be sincere and honest in all activities.

In order to establish this confidence and trust of his patient and maintain it in his professional work, he, as a physician, must continue to strive toward a more complete understanding of the whole patient. He cannot regard the practice of medicine simply as the treatment of disease by prescription of drugs or surgery. It is important that he remember to treat the patient with courtesy, kindness, sympathy and tact. Thereby he will be employing the art of medicine as well.

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PAUL C. TRICKETT, M.D.

Ectopic pregnancy means gestation not in the cavity of the uterus. The word ectopic comes from the Greek words, "ek" and "tropos" and means "out of place" or "displaced".

The site of implantation determines the variety. Extrauterine pregnancies accordingly are classified as tubal, ovarian, and abdominal. The same classification is applied to ectopic gestations but the latter also includes pregnancies in the interstitial portion of the tube and in a rudimentary horn of a bicornate uterus.

For the purpose of brevity and simplicity, this paper will deal with the more compact term of extrauterine pregnancies, hence I repeat, these are classified as tubal, ovarian and abdominal.

I feel that presentation of the case which gave birth to this paper is in order and it can best be followed by discussion of the topic. Indeed the case might set forth many dangerous and diagnostic points both ignored and missed. Although some books present these points as being easy to determine, they did not look easy to me at the time.

A 30 year old woman was referred to my service in the Beebe Hospital on March 18, 1953 by her doctor for immediate treatment and subsequent treatment of pregnancy.

Chief complaint of this patient on admission was severe pain in the lower abdomen and vomiting. Previous history obtained from patient and L. M. D. was that the patient was pregnant for the first time, had been married for eleven years and had practiced no birth control. Contributory past history showed a hospitalization in 1947 for pylorospasms and an episode of vaginal hemorrhage in December, 1952, which was treated at home and thought possibly to be an early complete abortion. Gynecologic history revealed that the patient had normal onset of menses at age thirteen and was regular, having her flow every 28 days but was subject to excessive bleeding and cramps and flowed for seven

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days. The patient also had a past history of prolonged and heavy vaginal discharge, with two or three treatments for chronic cervicitis.

The patient was admitted with a history of being in the third month of pregnancy. She had developed nausea and vomiting during the last 48 hours. The last menstrual period had occurred in mid-December, 1952. Physical examinations revealed the patient to be without fever and comfortable except for a state of moderate dehydration and bouts of vomiting. The patient had occasional severe abdominal cramps. Examination revealed, to the right of the umbilicus, a firm and movable mass. The abdomen appeared to be distended and tender. Pelvic examination showed supports of perineal floor to be good. A nulliparous cervix was seen and there a moderate amount of cervical discharge and erosion was noted. A Papanicolau smear was taken which came back negative. Further, pelvic examination revealed a positive Chadwick's sign and a positive Haegar's sign. The uterus was enlarged to the size of a two-and-one-half gestation and bimanual examination revealed a mass which appeared to be connected to the uterus in the upper abdomen. Impression at this time was:

1. Pregnancy, first three months.
2. Large fibroid tumor.
3. Pernicious vomiting of pregnancy.

The patient's stay in the hospital was uneventful and she was discharged on March 23, after conservative treatment.

On April 1 the patient was readmitted with the same complaints and while in the hospital developed vaginal spotting and had two or three attacks of low abdominal pains. This is a danger point which is often ignored or missed. At this time she was treated with progesterone and stilbestrol for both nausea and threatened abortion. She was discharged once again on April 11.

Subsequently the patient was followed in my office, being seen on April 24, May 12, and May 27. On the last date, her chief complaint was the occurrence of vaginal bleeding and severe low abdominal cramps and pain. Life had been felt by the patient on April 17, and the fetal heart beat was strongly heard on May 27th. At this time she was given progesterone in the office and again started on stilbestrol. This treatment had been stopped. Some physicians feel that once it is started it should not be stopped during pregnancy until the thirty-sixth or thirty-seventh week. However, it had been stopped. The spotting had started again, so therapy was resumed.

The patient was admitted to the hospital once more on June 11, because of cramps and general pain in the abdomen. Her blood pressure had fluctuated from 150/90 to 145/78 throughout the pregnancy and the total weight gained to this date was approximately three pounds. She was discharged again on June 16th and seen in the office on June 29th and July 28th. During this time she gained fifteen pounds and felt the best of any period of the pregnancy. On August 6 the patient was admitted again because of elevation in blood pressure up to 170/100 and because of spots before the eyes. During this admission the pelvis was measured and the x-ray report was as follows:

"There is a single intra-uterine pregnancy in the R.O.T. position. The fetal head lies above the pelvic inlet and the uterus is flexed anteriorly. The fibroid tumor is not demonstrated on this examination. The high position of the fetal head may be due to the fibroid tumor. The fetus has the appearance of a seven or eight month period of gestation."

At that time, it was my opinion that there was a fibroid tumor low in the abdomen. Instead of being behind, it seemed to have rotated or dropped. As the uterus had enlarged it had pushed down into the pelvis. I was certain when I saw the x-rays and examined her that she would not be able to have the baby normally. I began to plan for a section.

The patient was discharged on August 13 with a blood pressure count of 132/68. She was seen in the office on August 18 and August 25. She was admitted to the hospital on August 31 for Caesarean section on September 1. The diagnosis was near term pregnancy with uterine fibroid tumor making delivery impossible.

Total weight gained in the 38 weeks of pregnancy was 16 pounds and although the pregnancy had been agrorated, it was felt that the patient was in excellent condition with a blood pressure count of 128/72 and a hemoglobin of 13 grans or 84%. During the last two months of pregnancy, she could feel the fetal movements strongly. When I felt the abdomen I could move the baby quite strongly. This was another point that was either ignored or missed.

On September 1 the patient was taken to the operating room. An incision was made for a Caesarean section. When the peritoneum was opened a large, white, shining mass was noted which, at first, was thought to be a large ovarian cyst. Dr. James Beebe, Jr., was operating with me at the time, and I think both of us were surprised when we saw the mass. Upon palpation the mass was found to contain small, irregular parts and a tentative diagnosis of intra-abdominal pregnancy was made. The uterus was found to lie inferior and anterior to the mass and was enlarged to about the size of a two-and-one-half to three months gestation. It was soft and boggy.

The intra-abdominal sac was opened and the amniotic fluid removed. The baby was delivered by means of breach presentation. It cried immediately and appeared to be normal. The cord was clamped and cut and following removal of the baby the cord was carefully explored to the placental attachment. The placenta was seen to be attached to numerous loops of small bowel and to the sigmoid colon. Care was taken not to dislodge any of the placenta. We decided the best thing to do was to leave the placenta in. I believe she would have continued to bleed had I taken it out. The cord was ligated as close to the placenta as possible with a suture ligature and a hand tie. The operation was completed without difficulty and baby and mother rested satisfactorily and were discharged on the 18th day in good condition.

Frequent periodic checkups have been made on both mother and baby during the last three years and it is pleasing to note that the baby has developed normally. The mother has done well with the exception of frequent attacks of colitis and vague abdominal discomforts. She has had numerous abdominal x-rays and barium studies which have revealed a calcifing mass in the lower abdomen which probably has loops of bowel going through it. This mass is getting progressively smaller and denser.

A review of literature by this observer has failed to produce any similar cases in the annuals of Delaware medical history where a full term abdominal pregnancy was delivered and both baby and mother lived. Indeed, the last case that I was able to discover on record occurred in Stanford, Connecticut in the spring of 1949. By co-incidence, Dr. R. A. Gandie was a friend of mine, and I have not been able to find any other records. This case was reported in the Connecticut State Journal of 1950.

Everyone should recognize the danger signals ignored in this case. It was this postpartum recognition that caused my review on the subject of extra-uterine pregnancies.

The lobulated mass of the placenta is already calicfying along the edges. All the literature specifies that it does not, but it does. It has decreased half its size already, six months later, but it is still lobulated and large.

Finally, it is beginning to lose some of its lobular appearance. On pelvic examination I can feel it. I cannot feel it on rectal or abdominal examination. It feels like a lemon on pelvic examination, yet it is not that thick. It is narrow. I am beginning to doubt whether it actually has any bowel in it. At first I was certain it did. I was looking for an abdominal surgeon to remove it, but could not find one who would consent.

Implantations in the tube are much more frequent than other extra-uterine pregnancies and occur about once in every 300 pregnancies. Tubal pregnancies are most frequently ampullar, outer one-third; somewhat less often isthmal, middle one-third of the tube and rarely interstitial, inner or proximal one-third of the tube.

When diagnosis is made there is no expectant treatment. Immediate laporotomy is indicated whether it is before, at the time of or immediately after rupture or abortion. Shock and collapse do not contraindicate surgery.

Expectant treatment yields well over 50% mortality but surgical treatment or intervention less than 4%. Therefore, prompt and accurate diagnosis is important. One should be alert to, and cognizant with, the following symptoms and history:

(a) History of pelvic inflammation, sterility (especially one-child type), previous pelvic operations, and previous ectopic pregnancies (one in eight repeats—one in two has normal pregnancies).

(b) Pelvic pain associated with early signs of pregnancy—missed period; missed period followed by spotting, nausea, tender breasts; frequency in urination and occasionally rectal tenesmus. This condition is important also if associated with the early physical signs of pregnancy.

(c) Increased pelvic pain—often sudden, intense and in the region of the ovaries—followed by syncope and collapse.

It is not my purpose here to go into a lecture on diagnosis but given a case of a female of childbearing age with an attack of abdominal pain, always consider possibility of ruptured ectopic pregnancy regardless of the patient's social or marital status. Then proceed and rule out:

(1) Threatened intrauterine abortion;

(2) Ovarian cyst with twisted pedicle;

(3) Pelvic inflammatory disease;

(4) Acute appendicitis and

(5) Perforated duodenal or gastric ulcer.

Unfortunately, unruptured ectopic pregnancies usually are not suspected by either the patient or the physician prior to hemorrhage. Lack of signs of hemorrhage in the case just presented possibly made the diagnosis more difficult.

In rare cases, fertilization takes place in the ruptured graafran follicle before the ovum is expelled. In true ovarian pregnancies, therefore, the ovum is surrounded by ovarian tissue, and the fallopian tubes show no evidence of extrauterine gestation. Such pregnancies continue longer than the average tubal pregnancies. A small number are recorded as having gone to term.

The symptoms and treatment are similar to those of tubal and abdominal pregnancy.

Primary abdominal pregnancies are so rare that only a few cases have been recorded. Secondary abdominal pregnancies are more common and follow rupture or abortion of a tubal, ovarian or secondary ligamentous pregnancy.

Vaginal bleeding at the time of the primary rupture occurs in about one-third of all cases even though the ovum continues to live. Fetal movements often are painful to the mother and are easily palpated through the abdominal wall. Although all articles and texts said it was easy, I did not find it so in the case presented.

There is no greater obstetrical hazard than a live placenta outside the uterine cavity. If the fetus is alive laporotomy is indicated as soon as the diagnosis is made. The child has but one chance in 100 of surviving to term and then only one chance in ten of being normal.

If the case is near term and/or viability and the patient insists upon expectant treatment for the sake of a living child, the patient must submit to immediate hospitalization. The best time to operate for the mother is at once (generally the sixth to seventh months when diagnosis is made) and for the child in the thirty-sixth to thirty-eighth week. My case was in the thirty-eighth week.

Recommended procedure is to leave the placenta in and since this is safe, most physicians no longer wait following the death of the fetus. However, operate at once and then watch carefully with prolonged observation. The general rule is that the placenta sloughs out gradually but here we have shown a case of a slowly calcifing placenta.

In summary: I have presented a case of an extra-uterine pregnancy of 38 week gestation from which a living mother and infant resulted. The case shows how the placenta which was left has slowly calicified. Following this case presentation a review of extra-uterine pregnancies was made in an effort to determne how better diagnosis or diagnostic techniques could have warned me of this case.

Finally, it is pointed out, however, that if this diagnosis had been made two or three months, or even five months prior to surgery that the family probably would not have a three year old daughter today.

PRESIDENT VAN VALKENBURGH: Thank you very much, Doctor. We now will have a discussion of Dr. Trickett's paper by Dr. Giles.

DR. J. A. GILES, JR. (Wilmington): Mr. President:

Dr. Trickett has presented an interesting paper and certainly a most unusual case. I am sure most of us here have never seen such a case of advanced abdominal pregnancy and probably never will.

Considering the high fetal mortality, which is approximately 75% or more, as well as the high percentage of fetal abnormalities, he was fortunate to obtain a normal living child.

My discussion will be limited to advanced abdominal pregnancies only. Tubal and ovarian implantations will not be considered.

We can classify an advanced abdominal pregnancy as one of 28 weeks or more. Few cases of 37 weeks or more have been reported. There is no way to estimate accurately the incidence of this condition, but I would say one in ten to twelve thousand viable deliveries are made. It is more prevalent in the colored race with a ratio of sixteen to one. The only logical explanation of this ratio is perhaps the fact that colored people are slower to seek medical advice. Also the incidence of pelvic inflammatory disease is considerably higher.

Dr. Charlwood of South Africa has reported 52 cases occurring in teaching institutions in twenty years, all in Bantu women. Therefore it is not a rare condition among this race.

The diagnosis is seldom made before fetal death. Generally speaking, the diagnosis should be considered when there is a history of bleeding early in pregnancy associated with acute abdominal pain; late in pregnancy if there are vague abdominal symptoms and signs suggestive of intestinal obstruction. Practically all these patients have intermittent attacks of generalized abdominal pain which at times is acute. This is associated with nausea and vomiting. Vaginal bleeding is not always present.

The uterus is palpable separately and is usually the size of a three months pregnancy. Often it is assumed, as in this particular case, to be a subservus fibroid tumor. On palpation of the abdomen, the fetal parts are more clearly felt and are higher. The heart sounds louder than normal.

The cervix may help considerably with the diagnosis. The cervix is usually longer and firmer, the external os is closed and has no effacement. The position of the cervix is under the symphysis or high against the sacrum.

X-rays help. Films will show that the fetus has no surrounding uterine shadow and is placed high above the symphysis. Often it is in a transverse position.

These signs and symptoms lead one to think that the diagnosis is easy, but because of the rarity of the condition it may not be considered at all. The x-ray diagnosis is often made when the films are reviewed following a clinical diagnosis at the operating table.

I, personally, have had no experience with this condition.

Elective Caesarean section is done when on abdominal and vaginal examination a mass is felt which obstructs the birth canal, making vaginal delivery impossible. This mass may be diagnosed as a fibroid tumor or ovarian cyst. At operation it may be found to be an enlarged uterus, associated with an abdominal pregnancy.

I feel there could be no improvement in the obstetrical judgment in the case presented. On the basis of a fibroid tumor or an ovarian cyst, elective Caesarean section was the procedure of choice.

On pelvic examination a lithopedion can be mistaken for a fibroid tumor or cyst, but the diagnosis can be verified by x-ray.

As to management, Dr. Trickett stated immediate laporotomy is indicated as soon as the diagnosis is made. In rare instances, 33 to 35 weeks, when there is a chance of a normal baby, operation may be delayed if the patient is hospitalized. All cases, as he stated, should be operated between the 36th and the 38th week.

The post-operative course is smoother if the placenta is removed, but this is seldom possible. Removal of all or part of the placenta should not be attempted unless the operator feels there is no chance of hemorrhage. The placenta is usually ab-

sorbed in a few months with little difficulty.

The case presented is even more unusual because of the residual calcification of the placenta. Conservative treatment is still the one of choice, unless there are definite signs of real intestinal obstruction developing.

Thank you, sir.

PRESIDENT VAN VALKENBURGH: Thank you, Dr. Giles. Is there any more discussion here?

DR. GEORGE H. GARRISON: Dr. Van Valkenburgh, ladies and gentlemen:

I think Dr. Trickett is to be complimented on his handling of the case. Throughout his discussion he pointed out the fact of his error of diagnosis and stressed the fact that it was not until he did a Caesarean section that he was sure it was abdominal pregnancy. I do not know anyone who has been sure in the past because the condition certainly is diagnosed in advance.

I have seen only one case of this type in which there was also a viable baby and mother. It was at the Margaret Hague Maternity Hospital, a number of years ago —it could have been as far back as 1946. I am not positive of the year.

The interesting thing, I think, about ectopic pregnancies is that many physicians keep a high index of suspicion. As a result of a high index of suspicion many cases are mis-diagnosed. I am positive that many people are operated on for supposed ectopic pregnancy who do not have it. But it is only with this high index of suspicion that the ectopic pregnancies are discovered.

After most ectopic pregnancies rupture they are easily diagnosed—not the abdominal, particularly, but the tubal pregnancies—because the patient will go into profound shock and develop rebound tenderness and shoulder pains. To diagnose the ectopic pregnancy before the actual rupture or mass of bleeding takes place is difficult.

An interesting quotation I heard once is certainly worth remembering: "All pregnancies start as hemorrhagic phenomenas; hemorrhage at the start of the pregnancy and hemorrhage at the termination of the pregnancy. The question is the degree of hemorrhage and its location." When the trophoblast becomes implanted outside the uterus cavity, a laporotomy for the cure of the condition becomes necessary.

A few years ago Dr. Lull of Philadelphia wrote a paper on the treatment of the placenta in cases of abdominal pregnancy. He had a series of five or six cases, which pointed out that, in years past, when an attempt was made to remove the placenta, about 100% of the people died. In most cases when left in and tied off it was completely absorbed with no subsequent trouble. I think there was one case in which infection occurred, and an abscess had to be drained. However, in one or two of the cases of a series of five or six, when the abdomen was opened years later for another condition, no residual of the placenta or adhesions were found. This may suggest the fact that perhaps amniotic fluid in the peroneal cavity does prevent adhesions, though I am not sure of that.

Dr. Trickett said he left the placenta in, which was not only a wise choice but, I am sure, one based on his past experience. He said if he had not left the placenta in, the patient would have continued to bleed. I am sure she probably would have died. I think he could have finished it on September 1 without any additional trouble at all.

I am sure many physicians have had more experience than I have. I have seen only one, and it was not my case. There is a great deal of difference between seeing a case and being the doctor on the case. Seeing the case is interesting, but managing the case is an additional strain that Dr. Trickett faced, and I think he handled it well.

Thank you very much.

PRESIDENT VAN VALKENBURGH: Thank you, Dr. Garrison. Are there any other remarks or questions that you would like to ask the discussers or Dr. Trickett?

PRESIDENT VAN VALKENBURGH: Dr. Trickett, do you have anything further to add?

DR. TRICKETT: No, sir. I appreciate the discussion very much.

PRESIDENT VAN VALKENBURGH: Thank you, gentlemen. The next paper will be, "The Use of Obstetrical Forceps for the General Practitioner," by Dr. Rennie, from Wilmington.

USE OF OBSTETRICAL FORCEPS FOR THE GENERAL PRACTITIONER*

S. W. RENNIE, M.D.

It seems to me that forceps should have been developed before 1600, the date at which Peter Chamberlen is known to have invented this instrument. He kept it a family secret and it was not until three generations later that Hugh Chamberlen sold it to the Medico-Pharmaceutical College of Amsterdam. However, there is good evidence that he sold only one half—one blade of the instrument. In 1813 several of the original sets were found in the attic of the old Chamberlen home.

Further improvements were made by Palfyn, Dusee, Lenset and Smellie which have resulted in today's instruments. Several special instruments have since been introduced for specific types of deliveries, namely, the Kielland, the Burton, the Piper and a number of types of axis traction. The classical instruments are the Elliot, the Simpson and the Solid Blade of Tucker McLane. Although there is a tendency to use only one or two, further knowledge should make all these instruments available for the physician doing obstetrics.

I shall mention in developing this paper a few places where special and classical instruments may be best employed. I feel that the use of forceps has reduced infant mortality and dropped the morbidity rate in obstetrics. This is, with definite care, the proper application and adheres absolutely to definite prerequisites.

The purpose of the use of forceps is to apply traction to the infant's head and in many cases to act as a rotator. Never should they be used as a compressor as was done in Tarnier's time. Because Caesarian section was usually fatal Tarnier applied his axis traction plus a screw in the shank for compression. Today some compression may be made in many cases but not enough to create fetal damage.

At one time it was taught that the use of a single type of forcep would enable the operator to become versatile in difficult deliveries. However, I believe that several types of forceps can be of use and should be available. The operator should become adept at using various ones with ease and in certain cases one forcep will have certain advantages over another, making the maneuver easier and safer.

The cephalic application, that is, the blades equally placed over the sides of the baby's head is the one which should always be made.

There are several prerequisites which, if not fulfilled, will change the outcome of cases requiring forceps:

1. The cervix must be dilated or dilatable. An anterior lip might still be felt but can easily be pushed behind the presenting part. If the cervix is not dilated laceration and pressure on the head with intercranial hemorrhage may result. Should delivery become necessary before dilation is complete, manual dilation might be done. If this is not feasable Duhrssen's incisions at three points should be employed before traction is applied.
2. Correct diagnosis of position and station of the head is important. This is achieved by palpating the sagittal and lambdoidal sutures and the fontanels, or occasionally by the palpation of one ear. Frequently the fontanels are distorted by pressure making it necessary to feel the suture lines. Three suture lines radiate from the posterior fontanel and four from the anterior fontanel. The one vertex presentation where difficulty in diagnosis might arise is that of asynclitism. Posterior asynclitism presents an inverted "u" because the posterior parietal bone is presenting, making the cranial sagittal and lambdoidal sutures form this inverted "u." The anterior asynclitism presents a regular "u" on palpation. One might think this parietal bone to be the occiput. Such case usually occurs in a flat pelvis. For these simple reasons a definite category should be made for each patient's pelvis and measurements with other pertinent information such as Rh factor, serology, general condition and past history should be sent to the hospital by the

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physician's office at least a month befor the expected date of confinement.

3. The third prerequisite is ruptured membranes. If an unruptured sac is held between forceps and head, traction might cause placental separation and fetal anoxia.
4. The fourth requirement is an empty bladder and rectum. This situation decreases possible injury to these structures.
5. There must be no or very little disproportion. If disproportion is sufficient to cause difficulty, it should be recognized late in pregnancy or early in labor so that a Caesarian can be planned. If recognized during labor a Caesarian should be done as soon as possible, preferably a low cervical type with the use of antibiotics. There is a place for extraperitoneal Caesarian section but the indications are fast becoming less and less with the judicial use of antibiotics in cases of ruptured membranes.

With these few essential requirements present, I would like to enumerate some indications for forcep operations. These may be maternal, fetal or both. To quickly dismiss a subject, I think that outlet forceps with adequate episiotomy in prima-gravida or multi-para is an excellent procedure and the well-being and physical end result is better for the mother than allowing her to push the baby through and tear the perineum. The value of this procedure has been shown in 18 months' follow-up studies —midline episiotomies with outlet forceps gave the best results in 1000 cases.

To return to maternal indications which include the following:

1. The physical condition of the mother may make it advisable to lessen the second stage of labor. This condition may be intercurrent diseases, i.e.: heart disease, toxemia, tuberculosis and renal diseases; or an attempt to deliver a patient who has previously had a Caesarian, which is not my practice. I might add, I am sensitized against the procedure.
2. The mother may be exhausted. This condition is determined by pulse, temperature and blood pressure. It may be accompanied by acquiring secondary inertia which may be caused by rigidity of the cervix, lack of muscle tone producing a desultory type labor, dehydration and lack of sleep or by malposition with moderate disproportion causing a transverse or posterior arrest. Also the maternal soft tissues may be too firm with a rigid perineum or a scarred, hard cervix or vagina. The present day method of employing analgesics and anesthetics may cause a prolonged second stage labor. Therefore, I feel that if the head fails to advance one hour in a low position or two hours at higher levels, forceps should be employed providing the patient has definitely been having satisfactory contractions to that point.

Fetal indications are as follows:

1. Fetal distress may be evidenced by changes in fetal heart rate. Such rate fluctuating between 160 and 90 with some irregularity suggests difficulty with the baby. Passage of meconium in a vertex position suggests some asphyxia. Many times oxygen given to the mother for 10 minutes before delivery, rather than to hasten and create more difficulty and injury to the baby, will be invaluable to prevent fetal brain damage. This diagnosis of fetal distress is one which a nurse should be trained to make and she should be alert to recognize the condition if it is present.
2. Prolapse of the umbilical cord is also an indication for delivery. If the prerequisites are present, the forceps are indicated. If not, revision should be considered. Occasionally replacement of the cord and Caesarian is the method of choice.

The application of forceps is classified as:

1. High—at the plane of inlet.
2. Mid—at the plane of greatest pelvic diameter.
3. Low mid—at the plane of least pelvic dimension.
4. Low or outlet.

We will eliminate a floating head by saying it is a contraindication—absolutely. The

choice is Caesarian.

LOW FORCEPS—This application is the most simple. The head is anterior and is beneath the pubis. A cephalic application is done. The pelvic curve of the forceps will parallel that of the sacrum. It is wise always before application is made in any forcep delivery first to hold the forceps, articulated, in front of the patient in the position they finally will be after application. I usually insert the lower blade first because that is the easiest and correct cephalic application to be made. The second blade can then be made to articulate with the first. As a check each blade should be equidistant from each lambdoidal suture; the posterior fontanel one finger above the plane of the shanks and the sagettal suture at right angle to the shanks. When traction is begun, a finger tip is placed on the occiput to observe the descent of the head and note any slipping of the blades.

Episiotomies are routine on all primagravidas and usually are done on multiparas. I prefer a mid-line episiotomy because it is more anatomical. However, a mesolateral is excellent if it is done early, extensively, and with good clean repair.

A MID or LOW-MID application of forceps is made in a similar way except that at this stage rotation is not complete. Therefore, diagnosis of position of the head and correct application of forceps are more difficult.

Since many a vertex presentation begins as an occiput posterior, this condition might still persist. Pomeroy and Danforth advocate manual rotation to overcorrect after which the proper forcep should be applied. Simpson recommends the same procedure if the head is well moulded, or Elliott—if the head is round.

If this is impossible, the Scanzoni maneuver, with some modification, is done. I prefer this. The first forcep to be used is the solid blade Tucker McLane. It is as an LOA in an ROP, and as an ROA in an LOP position. The blades are locked and the head is not pulled down but is pushed back up the birth canal. The handles are then moved to one thigh or the other, flexing the baby's head. Next the handles are swung in an arc, thus causing the blade points to move in a very small arc and avoiding injury by laceration. The head is then in anterior position.

The lower Tucker McLane blade is removed and replaced with the proper Elliott or Simpson blade as for an anterior position. The second Tucker McLane is then removed and the second Elliott or Simpson blade is applied. A check at three points is made, Lambdoidal suture, Saggital suture, and the distance of the posterior fontanelle from the lock of the blades.

Traction is then applied to follow the proper mechanism of labor which is downward until the occiput is under the pubis, when extension delivers the head. Around the forcep lock I usually use a folded towel which acts as an axis traction. Instead one might use Bills' handle which will fit any classical forcep.

Some Obstetricians prefer a special forcept; the Kielland forcep, which has no pelvic curve and therefore need not be reapplied.

HIGH FORCEPS is application to the head which has not yet passed the superior strait. Therefore, with a contracted pelvis this operation is contraindicated.

If proper application can be made, axis traction in some form is necessary to pull downward, and at this level only axis traction can accomplish this maneuver. There are many developments in axis traction forceps. Dewees are the most common. However, the handle of Bills' can be applied to other forceps. The folded towel or the Dennen forcep with a curve in the shank can produce this type of pull.

Diagnosis, proper application, and constant observation as to slipping, etc., is mandatory.

We then come to the Special Forceps. The Kielland forcep has no pelvic curve. It also has a sliding lock which enables the blades to be placed in the Cephalic application although the head be in a mid, or high, transverse arrest.

In 1915 Kielland showed that if with the wandering maneuver of blades application could not be made, the anterior blade should be applied first in a spoon-like fashion and should enter the uterine cavity beneath the pubis where it can be turned to fit the head. On the shank is a dot or an arrow which

shows the way to turn the blade. It is then pulled outward to fix itself along the side of the child's head anteriorly. The posterior blade is then applied and fixed. Rotation and traction can be made with this forcep.

If however, the pelvis is flat Kielland's forceps are not to be used. Bartons forceps which have a hinged anterior blade are applied. They enable the operator to use traction and to pull the transverse head down to low pelvis before turning anterior. If an attempt should be made to turn before this is done, with a flat pelvis and a high transverse arrest, the parietal bone of the baby would be fractured on the pubis of the mother.

The PIPER after-coming head forceps should always be at hand with a Breech delivery. Should slipping occur, reapply the blades above the baby's back instead of beneath the abdomen if there is much flexion of the head.

I usually employ the towel around the locks of the classical blades to create some axis traction in nearly all deliveries.

SUMMARY

1. Forceps can be used routinely by general practitioners who do a large number of deliveries.
2. Forceps can cut down on maternal and infant morbidity.
3. Forceps require proper selection and accurate cephalic application.
4. Traction should follow the mechanism of labor in the axis of the birth canal.
5. Correct diagnosis of vertex must be made.
6. A check after application has been made is imperative.
7. Special forceps make special maneuvers easier.
8. Kielland forceps are a wonderful adjunct to the delivery room armamenatrium, especially for posterior and transverse positions.
9. Barton forceps are a must in case of a flat pelvis with a transverse presentation.
10. Manual rotation of posterior position should be attempted.
11. Scanzoni maneuver with Bills' modificator is an excellent procedure for a posterior position.
12. Piper forceps are used for after-coming heads. Kielland forceps may be substituted.
13. Kielland forceps are best for a face presentation with the chin posterior.
14. For the general practitioner who does only an occasional obstetrical delivery, the use of low or outlet forceps should be as far as he needs to go in operative technique. But for the general practitioner who does a greater percentage of his work in obstetrics, perhaps 50% obstetrics, operative vaginal deliveries should hold no fear and he should be versatile in all types of deliveries. He also should be a Fellow of the American College of Obstetricians and Gynecologists, attend their meetings and learn newer techniques.

Consultation should be mandatory in difficult cases.

In our hospital the following cases must have consultation:

1. Primagravida with ruptured membrances, for 24 hours.
2. Multipara with ruptured membrances, for 12 hours.
3. Abnormal presentation of any kind.
4. Multiple pregnancies.
5. Toxic cases.
6. Any other major medical complication.
7. Severe vaginal bleeding.

CONCLUSION

I have used excerpts from many texts and have attempted to present their highlights.

I suggest that physicians who do much obstetrics should buy and read the book, "Forcep Deliveries", by Dr. Dennen. This book has large print, is easily read, and is all meat.

I would also like to say that we who specialize welcome the general man who does obstetrics. However, we all should ask for help at times because it is much easier to do an operation with an assistant, and sometimes a suggestion is a wonderful help.

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DR. GARRISON: I would only say "Amen". I think it is an excellent and complete paper and I would like to add one thing. I think forceps often are used too frequently in cases where there is no maternal distress or anything wrong with the fetus; perhaps only for the obstetrician to get home more quickly. I do not think it is necessary to compress a head because forceps are not supposed to do this. They do it to a limited degree. The blood vessels in the fetal head are very fragile as we all know, and it would be pathetic to have a child perhaps ten years old remain in the first grade because of some injury from the forceps.

The second thought I can think of worth contributing which differs from Dr. Rennie, is that I like the Kielland forceps and I think they may be used in the flat pelvis. I do not like the Burton forceps for one particular reason; the hinged anterior blade. When one has traction with the Burton forceps the blade floats in mid-air and depends for stability on resting against the symphysis and the bladder. When traction is applied it is the only thing which holds the blade against the head, and I think sometimes one can injure the bladder badly in this way. The difference is not a major one —I suppose it depends on what method one is accustomed to employing.

But the paper as a whole was certainly excellent, and I enjoyed all of it.

PRESIDENT VAN VALKENBURGH: Thank you. Are there any other questions in regard to Dr. Rennie's paper?

DR. THOMAS: For one who does obstetrics extensively, I think there is a feeling of security in case of trouble with any forceps, besides the outlet forceps and the low-mid forceps, to have consultation all the time. Afterward it is possible to tell the father that he had someone else to be present, besides not exposing the fetus to the danger of becoming a ten-year-old baby in the first grade. I mean that truthfully.

PRESIDENT VAN VALKENBURGH: Does anyone else have any questions?

DR. L. L. FITCHETT (Sussex County): I would like to ask a question. Is there any place in obstetrics for using gloves on the blades? I never have used them, but they are available. Are they used at all in Wilmington?

DR. RENNIE: I believe one or two pairs were purchased. There is a special rubber gadget that someone invented. They did not seem to be necessary at all. I think a few physicians used them and found it was not necessary to use them at all. Some felt that they got in the way, and when they are sterilized, they tear easily. They also slip, and it requires another maneuver to put them on. Therefore, it was decided they were not necessary.

TRAUMATIC ACCIDENTS*

GEORGE O. EATON, M.D.**

First I should like to express my sincere appreciation of being invited to be with you at this meeting. Delaware is beginning to be a sort of second home to me, and my younger son and I are grateful patients of the staff of the Beebe Hospital. Therefore, I don't feel that I am on a lecture platform. I feel that I am talking to friends.

The subject of this talk might better be named, "Fracture Problems and Problem Fractures." The traumatic injuries to the chest, abdomen and head are so far out of my field that I certainly am not qualified to discuss them. I wish to discuss six general principles in the management of fractures which are too seldom emphasized, and which I believe tend to add to the surgeon's knowledge after he has been through sad experiences from lack of experience.

The first point, and possibly the most important point, is the necessity of a careful examination of the patient who has one major fracture—particularly in the case of an automobile accident. If a patient (and it is increasingly true if he is a passenger rather than the driver) is involved in a collision, he may injure his knee, or fracture his thigh.

One patient, a 26-year-old man, was in an accident in North Carolina and sustained a fracture of the shaft of the femur. He was

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treated for some seven or eight weeks in traction, but the fracture would not reduce. He was then posted and an open reduction and plating was done of the fracture. It was not until four months later that it was discovered that he also had a fractured dislocation of the same hip, which was undoubtedly the reason that the femur would not line up in traction. This condition could have been recognized early if an x-ray had been taken in the area.

Another patient was referred from Milford to Baltimore for further treatment. He was a truck driver, 33 years of age. He had an extensive fracture of the pelvis, plus a dislocation of the hip, and a fracture of the shaft of the femur. In this instance the double injury was recognized and treatment was directed accordingly. The treatment used was double-plating the fracture of the femur in order to obtain a lever with which to reduce the dislocated hip.

This case illustrates the fact that the head-on collision which produces a fracture in the knee or the shaft of the femur frequently causes a fracture or dislocation or both in the region of the pelvis and hip. It is of the utmost importance to the welfare of the patient that the condition be discovered immediately.

I have a patient who was treated in a hospital in West Virginia for a fracture of the patella. The patient told me that he kept telling his doctors that his hip was disjointed, but he was treated for the fractured patella. An open reduction was done. He convalesced for four months before he could persuade them to take an x-ray of the pelvis. As he had believed, the hip was dislocated and the end result was far from satisfactory because of the fact that the second injury was not recognized early in the game.

A 42-year-old woman who was unusually stout was injured near Frederick. At her request she was transferred within a day or two from the Frederick Hospital to Baltimore. I received a message that this patient was being sent to me with a fracture of the shaft of the femur. I left word at the hospital to the effect that when the patient was admitted I wanted an x-ray of the femur.

The technician asked, "What part of the femur?"

I replied, "I don't know. No one told me. X-ray the entire femur."

Because of that action, it was discovered that there also was a fracture of the base of the neck of the femur, in addition to the fracture of the shaft. It would have escaped notice entirely, I believe, if an x-ray had not been taken of the entire femur, because the symptoms of a fracture of the shaft of the femur. It could easily have been missed in a stout patient, and lack of early recognition would have militated against a good result.

A boy fractured the shaft of the humerus in the surf at Ocean City. He was taken to Salisbury (this accident happened a good many years ago) and at the hospital an excellent reduction of a transverse fracture of the shaft of the humerus was obtained. The boy was placed in a shoulder spica cast and because his home was in Baltimore he was transferred there where he came under my care. Since the reduction was excellent and was maintained in the shoulder spica, we elected to wait until eight weeks passed. When the cast was removed there was an obvious injury in the region of the elbow. It developed that the patient had a displaced fracture of the olecranon in addition to the fracture of the shaft of the humerus. It is interesting to note that the boy's mother took the attitude that the doctor should have recognized both fractures, and threatened legal action. The insurance carrier for the doctor in Salisbury agreed to pay further expenses, which settled the legal angle of the case. However, the insurance carrier recognized a possible fault in management by the original doctor since he did not recognize a double fracture. Anyone who has had a similar experience knows how easy it is to fail to recognize a double injury, and it may well be tremendously important to the patient.

The next point I would like to make is that if a dislocation of a joint accompanies a fracture of a bone and the surgeon has to choose between treating the dislocation or treating the fracture, he should consider the dislocation the more important of the two injuries and be certain to reduce the dis-

location. For example, a 17 or 18-year-old girl sustained a fracture of the pelvis plus a fracture of the femoral shaft, plus a dislocation of the hip on the same side. It was a service case. There were several consultations and several opinions were given as to how the patient should be managed. The procedure used was to treat the fracture of the pelvis first. The patient was left with a permanent sciatic palsy, which I believe was due to the fact that the dislocation was not reduced promptly.

In a case of a severe injury to an arm there was a fracture of the shaft, a fracture of the cervical neck and a dislocation of the humeral head.

The reduction of a dislocation depends upon leverage of the arm, and in this case the surgeon elected to do an open reduction and screw fixation of the humerus at the shaft. He then openly reduced the fracture dislocation of the shoulder at the same time. Undoubtedly it was the only way that the case could have been properly managed.

The end result was not good in that the patient developed a moderately severe aseptic necrosis of the humeral head, but that condition was caused from severe injury to the bone rather than the type of treatment used.

In ankle fractures there frequently may be found an associated dislocation of the ankle. It is of tremendous importance to correct the dislocation early. The fracture usually is amenable to open reduction, but a dislocation that becomes chronic and depends on open reduction is seldom a good result.

The capsule of a joint is composed essentially of fibrous tissue. If it is stretched in one direction and relaxed in another, it will contract where the capsule is loose and block later manipulations. Therefore, if there is a combination injury, it is indicated that the dislocation be controlled by whatever method is elected first; then a decision be made as to how the fracture will be managed.

The next point I wish to make—and possibly it is not as well appreciated as it should be—is that if one is treating a compound fracture and he needs an open reduction to get reduction of the displacement he should not wait long because of fear of infection. The basis for such philosophy is that if the fracture is going to be infected, it is better for the patient to have a fracture infected in good position than in malposition and displacement. I think this point may be obvious, but it seems to me that it is not appreciated and should be a fixed principle of action.

Concerning the question of manipulative reductions, I should like to stress that manipulative reductions call for skill but not for strength. There is no question that the sooner a patient can be subjected to reduction of a dislocation or a fracture, the better off that patient is. But the reduction should not be violent; it should not depend on brute strength; and it should not be repeated frequently. Reduction of any dislocation may be blocked by interposed soft tissue. Violence will add to the damage and may cause permanent disability.

A good illustration of this condition is the long head of the biceps drawn like a bow-string across the glenoid and preventing the reduction of a dislocation of the shoulder. It is not observed often, but it does happen. If one or two attempts at reduction with good relaxation are unsuccessful, the operator should stop and make a careful examination to determine what is blocking the reduction.

The same thing is true in the case of dislocation of the hip. Occasionally the sciatic nerve is caught over the femoral neck and repeated attempts at reduction will traumatize the sciatic nerve and will not lead to a successful reduction.

A woman from Washington had a dislocation of the mid-tarsis, and the foot was manipulated at least twice without any appreciable gain in reduction of the displacement. Traction with Kirshner wire was applied but that also was completely unsuccessful in reducing the displacement. At open reduction I found that the peroneus longus tendon was caught in between the tarsis and metatarsis, and the displacement could not be reduced until the tendon was lifted out. As soon as this was done the reduction was simple.

A condition labeled in the books as an irreducible dislocation of the thumb is not

very common, but is unforgettable. It is a hyperextension injury, in which the distal end of the first metacarpal is forced through the capsule and is locked there by getting under the tendons. Manipulation will not reduce the dislocation as a rule and open reduction is the only way the dislocation can be treated properly.

With that type of injury I believe that one attempt at manipulative reduction under good relaxing anesthesia is sufficient. If it does not reduce, the patient will be better off put on an open reduction. It is irreducible by closed reduction.

The question of the estimation of sufficient union to discard support is one of the most difficult. With some fractures a follow-up x-ray may show abundant callus but if the fracture is unsupported angulation and deformity can reoccur. In other cases the fracture seems firm, but the x-ray shows little or no callus.

I recommend that the surgeon depend on his clinical judgment rather than on x-rays for evidence of union. I cannot stress this point too strongly. I have been wrong several times, and from my experience I have found that if stress can be put on the fracture line without pain or apparent motion, the fracture probably is ready to be left out of plaster. If pain or motion are apparent at the fracture site, the fracture is not ready. It is better to immobilize too long than not long enough.

The last point of our general principles is the necessity of being cautious about the prognosis given the patient or family. Cases which seems to be difficult frequently turn out well. The reverse is equally true. Massive pulmonary emboli often will complicate a condition following open reductions of leg and thigh fractures. In such case a good prognosis on admission would have been erroneous. Fibrous ankylosis of joints adjacent to a fracture may cause a permanent disability. This would be hard to explain to a patient if he had been told that he should get well.

A patient 45 years of age received a fracture through the neck of the femur from a fall while ice skating. The treatment used was conservative. This happened about 1940, before nailing of hips was well established. He was treated by a spica cast and everything was done to insure the best possible result.

Eight years later he had an advanced aseptic necrosis of the femoral head which was not evident until three years after the injury. It has been a source of severe pain and limp. However, at the time of the original fracture, his age and activity would suggest an excellent prognosis.

A 17-year-old girl had an intertrochanteric fracture with satisfactory reduction and conservative management. It was treated in Russell Hamilton traction. In spite of her youth, good reduction and the distance of the fracture from the femoral head, she developed a severe aseptic necrosis of the femoral head. Because of cases like these I repeat that I think it is good management to encourage both patient and family to adopt an attitude of "wait and see".

Wire fixation in fractures of the fingers and metacarpals or metatarsals is a decided and recent advance. We are satisfied that putting Kirshner wires through joints in order to transfix a bone causes no damage to that joint.

With wrist fractures it is important to restore all angles and relationships if a functional wrist is to be the result. I don't mean to imply that restoration of all angles promises a good result, but it is important. The impacted fracture which has a disruption of the radio-ulnar joint frequently leads to a permanently painful wrist joint which may call for added surgery. In a badly comminuted fracture the addition of skeletal traction to the thumb is a help in maintaining reduction.

The hanging cast is an easy way to treat some fractures but it is fraught with problems. It is one of many methods which can be used in fractures of the humerus.

The Dunlap traction is an excellent method to be used for a super-condylar fracture in a child. The routine is much the same as when a good reduction cannot be achieved by one manipulation. If circulation is in jeopardy, treatment should be made by Dunlap traction. This method of treatment is preferable to open reduction.

A patient in Baltimore was involved in a severe automobile accident resulting in a fracture of the base of the skull. Anesthesia was impractical in regard to the management of the arm fracture. Some 17 fragments were found in the fractured humerus. Management of the patient was carried out by Magnesson splints and a minimum amount of treatment was required. Pressure dressings were removed and the arm re-wrapped as the swelling and hematoma disappeared.

The Magnesson splint is not the only good commercial splint made for treatment of fractures but it is a useful piece of apparatus in fractural work.

I recommend strongly that the mechanical support and traction be used rather than to have an assistant hold a broken leg while the cast is applied. This traction in two directions will prevent posterior sagging. There will be no worry about the assistant varying in the degree of pull he is putting on the leg. It is possible to set a fracture single-handed under local anesthetic if one chooses.

For uncomplicated fractures of the femoral shaft the medullary nailing probably is the best method of treatment available. It has been proved valuable and when used by a physician with good training and adequate facilities it offers a satisfactory and commendable way to manage a fracture of the shaft of the femur.

Dr. Haines from Clarksburg, West Virginia, has brought out his own apparatus which bears his name. I believe the Stater is more widely used. I mention this only to illustrate equipment which has been abandoned in most places for acute fracture treatment. It is not thought to be as good a way to treat fresh fractures as other methods available.

Many physicians have been interested in using double-slotted plates in order to avoid prolonged immobilization of a femur in either traction or in spica cast. The method is acceptable but I think we have better methods now, notably the medullary nailing.

A method of treatment which does not have the popularity which it deserves is the so-called ninety-ninety-ninety traction. In my training days we used it a great deal for subtrochanteric fractures of the femur with better results than any method I know. The patient can sit up in bed as much as is desired. Therefore it is good for use with elderly people. There is a minimum of apparatus and a minimum of gear to get out of place.

A simple apparatus was designed by Dr. Moore in Philadelphia. I am sure he is well known. I am fond of the apparatus. It is a simple piece of scrap iron which is easy to make and incorporate into a plaster cast. It is used for central dislocations of the hip. I use skeletal fixation, perhaps a half of a Haines unit, in order to get the traction on the bone. This method is efficient for reducing a central dislocation of the hip.

Fracture work and methods of treatment are still controversial in some fields, and I think that the best test of a method is whether a physician would want it used on himself. The measures I have recommended would fit in that category. From what I have seen I think they are good treatments for fractures and I take pleasure in recommending them to you.

Thank you very much.

DR. BAILEY (Wilmington): Mr. President and members:

Dr. Eaton has given his usual clear and concise presentation and, as Dr. Garrison said, about the only thing I can say is "Amen". I do know that the principles which he has presented are fundamental. If a physician adheres to them, his problems and troubles will be reduced to a minimum. If he veers from them, he is apt to get into trouble.

Commenting on Dr. Eaton's concept of union, I would like to add a definition which I learned from my old boss, Dr. Mather Cleveland. His concept was that whether or not union exists depends on whose patient it is. If a fracture is a little reluctant to unite and it is your patient, it is delayed union. If it is somebody else's patient, it is non-union.

Without appearing to present another paper following Dr. Eaton's paper, but because he did talk on fracture problems, I would like to add the problem of adequate soft tissue coverage in the treatment of

fractures. What I am about to present has been a joint effort on the part of Dr. Metzger and myself.

The first patient is a boy in his teens who was admitted to the Delaware Hospital in January, 1955, following an automobile accident. The initial x-ray was a shock and additional x-rays showed a part of the arm to be detached, a severe compound, transverse, somewhat comminuted fracture just above the middle of the shaft of the right humerus. There was extensive soft tissue swelling at the time of admission and several concomitant injuries demanded priority. Definitive treatment was delayed for approximately 13 days at which time debridement was used. It was found that the anterior compartment of his arm had undergone extensive necrosis, necessitating the removal of most of the biceps brachia, a portion of the brachialis, a portion of the coracobrachialis, and a portion of the outer head of the triceps.

The proximal fragment was impaled in the tendon of the pectoralis major. Since I agree completely with Dr. Eaton that it is better to have a potentially infected fracture, or an infected fracture in good position—I elected to insert the intermedullary nail and wire the loose fragments into place. It was markedly unstable without this. It was allowed to granulate, and about a month later I consulted Dr. Metzger, who at that time elected to put on several split-thickness grafts and do a rotary full-thickness graft, to cover the defect left by this debridement. The post-operative healing was not good. There was always a bleb or blister, and subsequent sequestrectomy was carried out about four months later. A month after that a combination full-thickness skin graft, combination flap and bone graft was made.

This combination bone graft and skin graft was done on November 7, 1955. X-rays in January, 1956 showed the original defect caused by loss of the fragment filled in with the ileac chips approaching even in the seven weeks a dull texture. I think this happened because it was adequately nourished. In Dr. Eaton's closing comments I would like him to comment on this combination full-thickness flap graft combined with bone grafting.

Dr. Metzger and I thought that we had not too much to lose. We certainly did not have the danger of going back through the area which had been grafted and losing skin which had originally been placed there. It resolved that this boy had enough left in his arm to get a reasonable result.

Another patient suffered a severe compound comminuted fracture of the tibia in March, 1955. I saw him in April, 1955, at which time debridement for extensive soft tissue and bone injury was carried out, necessitating the removal of a large amount of bone and soft tissue. This was allowed to granulate for approximately a month at which time we again elected to do some plastic surgery. The tibia was visible, covered by some granulation. There was a large area of poor, soft tissue and loss of tibial bone.

The cross leg flap graft covered it well. It was subsequently divided at about three weeks, and later developed a small draining sinus. This time we did not do the combination flap graft and bone graft. (Sik-e-skruk-toemy?) was carried out in September and approximately six months later bone grafting of the original tibial defect was performed in October, 1955. X-rays in January showed remarkable filling of the original defect, again because the bone had adequate nourishment. X-rays in July, 1956 are of the same appearance except that the bone is more adult in form. The patient is wearing a long leg brace for immobilization and has been weight-bearing on it since April. I think he probably needs additional bone. I am afraid that if he were allowed to bear weight without immobilization he might develop a stress or strain fracture.

Anyone who deals with bones is aware that unless they are adequately covered, protected and nourished, they do not unite readily and often do not unite at all.

Thank you.

DR. JAMES: Mr. President, fellow members:

You have just heard two experts this morning. My proper place is in the "Amen" corner.

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these two men, but I should like to tell you, and of course you are well aware of the fact, that all serious injuries do not occur in the centers where experts are available. However, in Milford and throughout the lower section of Delaware I think we have good x-ray men. They encourage physicians to take multiple x-rays of injured cases trying to find all the damage that has been done. I would like to stress the point that Dr. Eaton made, that frequently when the physician sees the injured patient, the obvious injury causing the serious trouble and shock, frequently is not the only one.

In the past year I can remember several serious cases. One was a compound dislocated ankle, and in addition to a few superficial cuts around his face, the boy also had a dislocation of the hip.

Another case I remember had a fracture of the lower leg, a severe injury to the chest, with multiple rib fractures, and severe contusions of the breast. Again there was a dislocated hip. I recall that when the lacerations were closed and after the obvious deformity, which was a compound fracture in the lower leg was treated the anesthetist told me the girl was unable to give complete relaxation for work on the hip. I postponed doing anything to the hip until two days later, when he thought that her vascular system was well established and the shock overcome so that we could get complete relaxation.

I was called out about four hours after we finished. She had gone into shock, and I had to do a cut-down to get blood going. By postponing our work on the dislocated hip we had no difficulty at the end of 48 hours, and she had good result with no trouble from the hip.

It has been my experience that it is much easier whenever I can to find a dislocated hip at once and treat it immediately. It also is important to get complete relaxation. With modern drugs the anesthetists use now which cause the patient to sleep quietly, I find I get better results if I wait until the patient is in condition to have a spinal. Then I wait until I know the spinal is in effect, that the muscles are completely relaxed, and I do not have to use so much force.

I teach a class of nurses at the school and one of the subjects which comes up is burns. I suppose all teachers as they get older develop a special theory they like to stress. When discussing burns, I ask the nurses, "What is the best treatment for burns?" Of course, I get a number of answers. There are many text books written on the subject. However, I tell them that the best treatment is prevention.

I was called on a Saturday evening to see an old colored man. The resident told me he was seriously injured with a cut elbow. It was difficult to get his blood pressure and fluids were being injected. He had a severe laceration of the right elbow with one nerve exposed and better identified than in any place I had ever seen except a text book. Exploring the wound a little later, I found that the median nerve was completely cut. We treated it as shock, and by means of taking x-rays right on the stretcher I was able to find that the man had multiple fractures of the ribs. He had nine fractures on one side, three fractures on the other, and among the fractured ribs the first rib on each side was fractured. I do not know how a first rib can be fractured without the clavicle being fractured. However, there was no damage done to the lungs. I did not do anything until shock had been treated and it was safe to take him to the operating room. We closed the wound in the right arm without moving him from the stretcher. We did not try to attempt repair on the median nerve because shock did not permit. There is one observation which I made, and would like to call to your attention—particularly to the orthopedic surgeons. His clothes were wet and had sand in them. There was sand in his hair, but he was fortunate enough not to have a head injury.

I asked him what had happened to him. He whispered that he was thrown from a car and landed in a mud hole. It has been my personal experience, in checking these multiple injuries and watching the ones which are brought in dead, that there has been a high percentage of patients who have been thrown from a car—30% to 50%. I think in consideration of that factor doctors should keep in mind the benefits which might be derived from the use of safety

straps in their cars. Not only that, I think they should consider seriously the example set for the public if they used them.

I asked what happened to the driver of the car in which the man was injured. He was sitting in the hall with a scratch on his nose. He had remained in the car.

Thank you.

PRESIDENT VAN VALKENBURGH: Thank you, Dr. James.

Dr. Eaton, do you have anything to add in the way of summation?

DR. EATON: I have little to add except to endorse Dr. Bailey's philosophy of soft tissue coverage over delayed or non-union of bones. My experience has been that a thick flap of skin and subcutaneous tissue over a non-union will facilitate a union without further bone surgery. Dr. Bailey's philosophy of doing them both at one time has merit in that it may well cut down time which is taken up in the total convalescence.

Dr. James, I do not know whether you want me to answer your question concerning why a first rib was broken and a clavicle was not. My opinion is that because the first rib is attached to the sternum and the clavicle is only a joint with the sternum, there was pressure on the sternum which broke the first rib.

Thank you very much.

PROCEEDINGS OF HOUSE OF DELEGATES

(Continued from November Issue)

If that is the case, perhaps that could be corrected by better liaison between the AMEF and the medical schools.

PRESIDENT VAN VALKENBURGH: I don't think they have the right understanding. That is supposed to go direct to the medical schools and be credited to the AMEF.

DR. J. R. FOX (Dover): There is a good deal of severe criticism from our own medical schools to that type of contribution and a good deal of resistance to it.

DR. MCGUIRE: I can say this, Dr. Fox, that if you label your contribution to the AMEF to just the Jefferson Medical School, Jefferson Medical School will receive it and you will receive acknowledgment from your Dean.

DR. BEEBE: Why won't the medical schools accept it that way? I wrote directly to my representative and asked him if I contributed directly to the AMEF, with the stipulation that it go to Jefferson, would that be all right? And he wrote back and said, "Absolutely not," that my class would not receive any credit at all if I contributed directly to the AMEF.

DR. MCGUIRE: This is contrary to the fact, as I am apprised of it. Now, there are many people who are using the idea that they are contributing to — and I am not saying that any individual here is involved in this — contributing to their medical schools directly. I believe it is next October, Dr. Fox, October or February, we will get a record of all the men in this State who have made individual contributions to their medical schools direct. Now, this is a national organization set up by the American Medical Association and the American colleges of medicine of this country. There is nothing specious about it at all, and you are still entitled to make and should make a contribution to your own school. All this Society asked last year I think was $25 from each member, and we got 36%. Now, it is not taxation at all; it is a contribution.

DR. J. R. FOX (Dover): Don't accept my remarks as derogatory. I did not mean that. I felt that the whole solution, or at least an easing of the number of participants and an elevation of the percentage of participants could be very easily achieved if there was better liaison on a national level between medical schools and the AMA. I know a lot of people who directly contributed to medical schools that the AMA did not hear about.

Now, if the medical schools and the AMA can get together so there would be an immediate transmission of names contributing directly to medical schools and they would appear on the AMA files, then I think a lot of these problems would be avoided.

As Dr. Beebe pointed out, the class representatives for our particular group are very much opposed, and even the Dean in private conversation is opposed to receiving funds through the AMEF because of the delay, or whatever criticisms they have. But I feel sure that the percentage of contributors in the State of Delaware would be elevated considerably if some sort of liaison could be worked out between medical schools and the AMEF.

DR. JOHN W. ALDEN (Wilmington): Mr. Chairman, I would like to say something.

PRESIDENT VAN VALKENBURGH: Dr. Alden.

DR. ALDEN: I feel this is an important thing. There was one question I wanted to ask and then I would like to make some remarks about the collection of funds.

I have never served on any committee for this, and I made my contribution through the AMEF and directed it to my medical school, which I think many of us do. Will somebody tell me if this figure of 36% includes people who contributed directly to their own medical school?

DR. BAILEY: No.

DR. MCGUIRE: No.

PRESIDENT VAN VALKENBURGH: It is not included.

DR. ALDEN: My other comment about this is that every year the members who are delegates hear roughly this same discussion, that not enough of us are contributing yearly to the AMEF. Then once or twice a year perhaps at the County Medical Society the chairman of the Committee on the county basis will make some comment and urge the members to participate in this program.

Would it not be better to do this the way the professionals do and have a drive in which the whole thing is concentrated in a period of perhaps

(Continued on Page 354)

Editorial

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THERE'S NOTHING WRONG BUT . . .

All of us have been guilty at one time or another of telling a patient, "There's nothing wrong—but don't climb stairs" or "There's nothing wrong—but take this medicine."

Such statements are ridiculous and confusing.

Surveys of public attitude have shown that inadequate discussion of the patient's condition by the physician is a top-ranking complaint.

The ability to inform a patient that nothing is wrong is one of the most satisfying rewards a physician can receive in the practice of medicine. Let us spend more time in exercising this privilege: we will become better doctors and our patients will be more appreciative.

THE BUSINESS OF PRACTICING MEDICINE

The New Castle County Medical Society was privileged in November to hear an expert speak on the above subject.

Our observer reports that the speaker developed the thesis that if the private practice of medicine, as we know it, is to be continued, the medical profession must preserve the means of paying the cost of treatment and hospital care. To this end physicians must support and encourage the development and operation of voluntary group prepayment plans.

Doctors must keep abreast of the times, medically and otherwise. Sound business practices must be used. These include, among other items a clean, attractively decorated, comfortably furnished set of offices, which will display without fail a variety of *current* periodicals.

It was stated that the physician's practice should be "in balance," which is to say that the volume should be "right" as should his fees, his collections, his overhead and the mangement of his patients.

The volume is "right" when the number of patients does not exceed that for which he can properly care. Such care must be reckoned in terms of his physical and mental ability as well as his professional interests.

The fee is "right" when it is paid cheerfully. It should be neither too low nor too high. How is this problem solved? By frank and honest discussion with the patient of the considerations, which leads to setting the fee before rendering the service.

In one way or another, bad collections reflect bad management on the part of the doctor. Collections and overhead should be in balance.

Economy means wise spending. This includes the employment of a competent secretary with pleasing personality, the installation of a double entry system of bookkeeping, daily deposits of collections and the service of an accountant to fill out income tax returns.

Also, every doctor should realize that public and human relations begin at the entrance to his waiting room. They necessitate understanding people. Patients need the personal attention of the doctor. They have a right to know what to expect as a result of their visits to the doctor, the laboratory and the hospital. They need to be told why tests are necessary and why charges are what they are.

So far as the patient is concerned the cost of medical care is a loss. He must be helped to understand that, in truth, he is trying to buy health.

WOMAN'S AUXILIARY

I am happy to have this opportunity to greet you, as Auxiliary members, a privilege we share, and to tell you some of the highlights of our program for the year. Basic plans were offered at the Thirteenth Annual Fall Conference for State Presidents and Presidents-Elect in Chicago on October 1-2-3. I will attempt to explain how they apply to our State Auxiliary and the manner in which, I trust, they may reach a successful conclusion.

The primary project is Health Education and our National Theme for this year is "Health Is Our Greatest Heritage". We must exercise every effort in our own communities to preserve this heritage by offering constructive plans for better health and living.

We can serve individually by participating in the health activities of our local schools, of P.T.A.'s, and other related groups, and by maintaining a close contact and a sincere interest in the schools our children attend.

Then too, there is no better way to promote health education than by the sale of "Today's Health". This is the only authentic health magazine published for the laity, containing truthful medical facts. "Operation Christmas Supplies" is ready and awaiting your order. Why not order a gift subscription for your own and for your husband's family? You can bet they'll enjoy it—twelve months of the year—and will want to renew the subscriptions themselves. Would it not be nice to have our Auxiliary honored at the 1957 meeting in New York City? Mrs. Allan Cruchley will appreciate your assistance in obtaining this goal.

Last year, the National Auxiliary gave $106,000 to the American Medical Education Foundation. This year, our quota is $140,000. An easy way, for each of us, to raise our share is to use the new "In Memoriam" cards and the "In Appreciation" cards. These may be obtained from our A.M.E.F. Chairman, Mrs. Roger Murray, 613 West 10th Street, Wilmington, Delaware.

The Nurse Recruitment Committee has been changed this year to "Recruitment" as we want to encourage young people to study other fields allied to medicine, such as Medical Technology, Medical Social Service, Physical and Occupational Therapy. The need for nurses is as old as pain and this Committee attempts to alleviate, to a degree, this shortage and, at the same time, offers financial assistance to many worthy young girls.

Mental illness is one of our major health problems. This year, we are placing emphasis on psychiatric problems in children, as part of our Mental Health Program. It is rewarding to me to observe how this country is rapidly becoming Mental Health conscious. Almost daily, we read articles relating to this problem. We often are privileged to attend forums and panel discussions aimed at focusing public attention on this subject. Mrs. Richard Comegys is our very capable Chairman and you will hear of her plans early in the new year.

Civil Defense continues in importance—it is a way of life. We must be prepared for all kinds of disasters. The more informed and the greater our skill, the better prepared we will be to meet any situation. If an atomic attack comes it will call for a national community effort, it will be your efforts, as well as mine. Just this week several of our members received a word picture of a Post Attack Situation, as well as a preview of Mr. Disaster, at the Disaster Institute held at the Wilmington Armory.

What was your specialty before marriage? Whatever you did, the Civil Defense Chairman of Delaware can find a spot for your volunteer service. Why not call, register and, as physicians' wives, show your

interest in helping in your respective communities?

The Bulletin has had a face lifting and I know you will approve the change. Mrs. Joseph Davolos is striving to increase subscriptions to our National Publication. I hope all County Officers, State Committee Chairmen, as well as many members will subscribe. To be an interested Auxiliary Member, you must be an informed member and there is no better way of receiving information than by subscribing to and reading The Bulletin. Let each of us be a committee of one and when traveling on official business carry a sample copy to help stimulate interest.

This year, we have a new committee—Safety. Our moral obligation to prevent accidents to ourselves and to others transcends any other motivation. We must work together in a spirit of good will to prevent accidents of all types. No matter how extensive the destruction of materials in an accident may be, materials can be replaced. Dead and maimed human beings, their skills and their intelligence cannot be replaced.

This does not cover all our Committee Chairmanships, but they will be included in subsequent issues. I would enjoy hearing the projects and accomplishments of our County Auxiliaries, and any new ideas would be greatly appreciated. If you have a problem—and who hasn't—be sure to contact me and I will attempt to aid you in working out a solution. Listed below are your officers and committee chairmen for the ensuing year:

President
Mrs. H. T. McGuire, New Castle
Vice-President
Mrs. Lawrence Fitchett, Milford
President-Elect
Mrs. Roger Thomas, Wilmington
Recording Secretary
Mrs. William Reardon, Wilmington
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Public Relations
Mrs. Harold Mercer, Dover
Revisions
Mrs. Glenn Van Valkenburgh, Georgetown
Recruitment
Mrs. George Eriksen, Wilmington
Today's Health
Mrs. Allan Cruchley, Middletown
Safety
Mrs. Martin Pennington, Wilmington

Signed
Mrs. H. T. McGuire

ANNOUNCEMENT

The Ninth Annual Clinical Conference of the Staff and Society of Ex-Residents of Wills Eye Hospital will be held at the hospital on February 8 and 9, 1957. The Conference this year will be of special interest since it will be an important feature in commemorating the 125th anniversary of the founding of the hospital.

The Bedell Lecture will be delivered by Dr. John M. McLean of New York City, on the subject of "Management of the Primary Glaucomas."

The program will also include scientific papers by members of the staff and ex-residents of the hospital, technical exhibits and a color television program sponsored by Smith, Kline, and French Laboratories

which will present ocular surgery, case presentations and demonstrations of procedures and techniques.

On Friday evening, February 8, there will be an informal reception and supper for the ophthalmologists and their wives. On completion of the two-day program, the Wills Eye Hospital Society will hold its annual meeting and dinner at the Union League, Philadelphia, on Saturday, February 9, 1957 at 6:30 P.M.

Prior to the conference there also will be a meeting preceded by dinner, of the Ophthalmological Section of the College of Physicians in Philadelphia on Thursday evening, February 7, 1957, at which Dr. James H. Allen of New Orleans will be the guest speaker. All ophthalmologists are invited.

BOOK REVIEW

DERMATOLOGY. By Donald M. Pillsbury, M.A., D.Sc. (Hon.), M.D.; Professor and Director of Department of Dermatology; Walter B. Shelly, M.D., Ph.D., Associate Professor of Dermatology; and Albert M. Kligman, M.D., Ph.D., Associate Professor of Dermatology, University of Pennsylvania School of Medicine. Cloth. $20. Pp. 1331, with 564 illustrations. W. B. Saunders Company, West Washington Square, Philadelphia 5, 1956.

Here, at last, is a textbook with an approach that is so novel and refreshing that it might well serve as a model for texts in all branches of medicine. It is obvious that when this book was written no older book was at the elbow of the authors. For it is a brave and successful attempt to break through the babel of dermatologic terminology, the fallacies of injudicious therapy, and the loose thinking that has for so long been associated with the pathogenesis of many skin diseases.

The book begins with the anatomy, physiology, and chemistry of the skin and its appendages. Much of this material represents the results of research done by the authors themselves. Each chapter could well serve as a monograph on the subject which it describes. The remaining sections are devoted to allergy, principles of diagnosis, therapy, and finally the clinical discussion of the various skin diseases.

The pictures are superb and almost all of them are of patients whom the authors have observed personally within the past ten years. Similarly the clinical discussions are based almost entirely on the experience of the authors and are characterized by an honesty and objectivity that is indeed rare in medical texts. The bibliography is simplified by including only one or a few key references to the subject matter in each chapter. Finally, the text is written in an informal manner that makes its reading more like listening to an informative and stimulating lecture.

L. K.

PROCEEDINGS OF HOUSE OF DELEGATES

(Continued from Page 350)

two weeks? You get this little card from the AMEF — I generally stick it to my check book. But I could just as well lose it at my desk in the hospital and forget to make a contribution. But if it were done on a concentrated basis, I had a notion we would have a chance of reaching more of our members than at the present time, being done on a piecemeal basis.

DR. BAILEY: Have you ever walked into someone's office and asked him for money?

DR. ALDEN: I know it is tough, but the Red Cross collects money that way, also the Cancer Society — all the people who really know how to collect money are doing it that way. I think we have something.

DR. CANNON: I want to say one thing. This AMEF contribution should be over and above what you ordinarily give to your medical school because if you only divert what you give to your medical school as an AMEF contribution, the AMEF is not adding one penny to what the medical schools are trying to get. And this should be in addition to what you have committed yourself to your medical school or your class. And if it isn't in addition to that, I don't think it is worth anything.

DR. BAILEY: I think we are losing sight of one thing that Dr. McGuire stressed, and that is being behind what we say, being consistent with what we argue about. If we give 100% to this thing, and it can come out in figures that the doctors are contributing 100%, we have something to back up our argument. I think that is very important.

DR. MCGUIRE: I would just like to make this comment, that a large part of the AMEF funds now are coming from the pharmaceutical industry, the steel industry, and the automotive industry, all of which you very well know is either tax deductible to them or added to the product which you and I buy. Oil companies, shipping companies, are giving to this thing. And they are saying, as a matter of fact — I didn't see this or hear it — but I was told that they had some people at the Chicago meeting asking to kindly pass the word around that they do not like the disparity between what industry and finance and commerce are giving as to what the doctors' contribution is.

There is no question of the need of medical schools. That is absolute. This is a thing — it was voted down, 13, 23, to give money to the University of Mississippi who cannot pay for the bricks they have already laid. So there is a kind of fix for you.

But this thing, the contribution you make as an alumnus of Jefferson Medical School, is apart from this. It is a devotion to Jefferson. This is a

devotion to American medicine, American stability, American constitutional government, and so on.

All of us alumni — I gave a little bit to the University at Pittsburgh. But that is a sentimental thing. This is a practical thing, and it transcends, as Dr. Cannon says, the other.

I will not say any more, but I am sure Dr. Murray, who was at the Chicago meeting, can give you the real dope.

DR. MURRAY: I don't know that I can add anything.

DR. J. L. FOX (Sussex County): I had a little experience trying to collect for the AMEF in Sussex County, and I met with considerable opposition.

I also realize it is our duty to contribute to this AMEF, and the medical schools have had considerable difficulty. For instance, at Jefferson you do not get any credit on your class contribution. I believe the medical school gets a lump sum from the AMEF, which is a total of all the contributions. But the individual contributions and the classes are not broken down.

I would suggest that the secretaries of the County Medical Society be requested to send out a voluntary assessment and mail it at the same time they mail the dues. However, I feel if we put a compulsory assessment on the dues and raise the official dues of the State Medical Society, I believe that will meet with considerable opposition because the AMEF, as I see it, is a voluntary contribution, and although we feel the responsibility, I do not feel that the State Medical Society should dictate whether we give or whether we do not give. I think we should keep it on a voluntary basis, and by collecting it through the Secretary-Treasurer of our County Medical Societies, I think possibly we might increase our percentage of collections considerably.

DR. R. W. MURRAY (Wilmington): I think probably everything has been said which can be said. I think the gentlemen are wrong when they talk about Jefferson Medical College. If you look in your Alumni bulletin you will see the list of contributions by each member of each class, and alongside some names you will see an asterisk or mark of some kind, and you look at the bottom of the page and you will find that means that individual has contributed both to the American Medical Education Fund and also to the Jefferson Alumni fund.

I think Dr. Beebe's class representative is in error when he told him that wasn't the case.

I am very much in favor of the appointment of a committee, and I think the thing ought to be discussed at County Medical meetings where you have a much larger group to talk the thing over. I think I personally would be in favor of raising the dues so that everybody makes an equal contribution to the Medical Education Fund.

DR. J. W. HOWARD (New Castle County): There is one point that has not been discussed, and I suspect that it is a very poignant factor in the background, though I think that the time is coming that the medical schools are getting together with the AMEF.

I have had an occasion to talk with several representatives of the medical school, and the one opposition that I find they are making to an assessment on a county-level basis is that it will stereotype the contributions of individual members who have in the past given more to their medical school.

I think the suggestion made earlier by one of the discussers that as time clears, this relationship between the medical schools and the AMEF will disappear. But that is one of the fears of several medical schools, that if we adopt a certain figure of $25, when someone in the past has been giving $100, he might not do that.

DR. BAILEY: Who said that?

DR. HOWARD: I have talked with the Assistant Dean at Penn.

PRESIDENT VAN VALKENBURGH: Is there any other discussion?

DR. MCGUIRE: The only comment I can make on that is, this is sort of an illegitimate child of the medical school. And if that is so, he is denying his progeny.

DR. HOWARD: I think the whole thing is changing. But that is one of their thoughts, they are afraid they are going to lose something.

DR. MCGUIRE: The relationship should be good because it originated there.

DR. HOWARD: They want us to contribute both ways.

DR. MCGUIRE: It originated in the House.

PRESIDENT VAN VALKENBURGH: They give you credit, as Dr. Murray has said, because that has happened in my individual case.

DR. ITALO CHARAMELLA (Wilmington): In my case, too.

PRESIDENT VAN VALKENBURGH: But it should be in addition to, and I think Dr. Beebe is correct, and if they did not give him credit for his class contribution — they would give him credit for what he had given.

DR. BAILEY: Could I say one more thing? I attended this Chicago meeting of the AMEF about three years ago on a so-called national level, and their greatest recommendation was unified assessment, not voluntary assessment, but just added to the state society dues. That was the Utopia, and anything under that they hoped they could get. It is a matter of putting money where your mouth is. If you can talk with a physician and he can say, "We are giving 100% — not necessarily one thousand million dollars, or anything like that, but that the medical profession is behind this thing 100%, industry, commerce, and so forth are going to give and give much more freely and more.

PRESIDENT VAN VALKENBURGH: Is there any other discussion?

DR. R. W. FRELICK (Wilmington): The discussion as to the credit the individuals will get for giving to the Fund and to the medical schools, it seems to me you have to discuss also the credit that the AMEF should have to present to industry, that so many people give either through them or to the medical schools.

It is certainly agreed that something has to be worked out on a national level. For example, people who are giving to the medical schools individually, this should mean as much to industry as if they are giving to AMEF. It looks as though there is going to have to be some stabilization of credits so that industry really knows how much is being given, so that the credit thing works both ways.

PRESIDENT VAN VALKENBURGH: I think you have a point there. There is a resolution, Dr. Cannon, isn't there?

DR. CANNON: There is a motion on the floor to appoint a committee to study the matter of increasing dues to cover AMEF contributions. That motion was made by Dr. McGuire and seconded by Dr. Bailey.

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: The Representative to the Delaware Academy of Medicine.

Report of the Representative to the Delaware Academy of Medicine

As in the past years, the Academy continued to render a valuable service to the medical profession as well as the lay public and the community.

In the fall of 1955 the Wilmington Council of Churches, in cooperation with the Academy, conducted an Institute on Pastoral Care. Three of the four meetings were held at the Academy.

One of the most important happenings has been the Medico-Legal Symposium on April 8th sponsored by the Medical Society of Delaware, the Delaware Bar Association and the Academy. The meeting was held at the Hotel Du Pont with over 200 in attendance, approximately two thirds of whom were from the medical profession. A resolution was adopted at the close of this meeting calling for a joint standing committee to be created by the Medical Society of Delaware and the Bar Association. This committee already has prepared a draft for an "Interprofessional Code of Conduct and Practice" to be adopted by the two respective organizations.

The Public Health Forums were continued, as in the past, as a joint enterprise with the Academy, the News-Journal Company, the Welfare Council of Delaware, and the Group Hospital Service.

The Academy was one of the co-sponsors of a most successful Delaware Science Fair held at the Tower Hill School.

On April 21st the Academy was the co-sponsor with the Alfred I. Du Pont Institute of a Symposium on Fractures and Trauma arranged for the Delaware Chapter, American Academy of General Practice.

One of the most pressing problems is the need for a larger meeting hall and additional rooms for offices. We have outgrown our present facilities in the present Academy building in more ways than one. With over 300 members of the County Society and only 100 seats in the meeting room, there is standing room only for the well-attended meeting. A Building Committee, with a former Academy president, Gerald Beatty, as chairman, is now hard at work. The Academy's architect, Mr. Albert Kruse, has submitted the first set of preliminary drawings on an auditorium addition to the present building. For the new building it will be necessary to acquire additional land, either from the Bancroft Company or the city. It is hoped that the building program will be a reality sometime during the coming year.

The Library collections now have over 1200 textbooks, among which a considerable number are late editions. Nearly 200 periodicals are currently received.

The professional membership of the Academy is 262 members (227 physicians and 35 dentists).

Respectfully submitted,

W. O. LAMOTTE, SR., M.D.

PRESIDENT VAN VALKENBURGH: Any discussion on the report of the Representative to the Delaware Academy of Medicine? Is there a motion to accept and approve the report?

(A motion was made, seconded and carried to approve the report of the Representative to the Delaware Academy of Medicine.)

PRESIDENT VAN VALKENBURGH: There was a new committee listed here, as mentioned in this report, and I had mentioned it and so had Mr. Morris, the Medico-Legal Committee, which was appointed in regard to this symposium. Dr. Washburn is chairman of that committee, and I recognize Dr. Washburn.

September 11, 1956.

To the President and Fellows of the
Medical Society of Delaware:

On Sunday, April 8, 1956, the Delaware Academy of Medicine sponsored a meeting to which were invited all members of the Medical Society of Delaware, The Delaware Bar Association and the American Academy of General Practice, Delaware Chapter.

The meeting was held in the Hotel Du Pont in Wilmington and was supported financially by the sponsoring organizations, The Medical Society of Delaware and the Delaware Bar Association.

The objectives of that meeting were: To establish friendly relations between the individual members of the medical and legal professions, to invite authoritative speakers to present their views on problems confronting the professions in the discharge of their obligations to society, with particular regard to medico-legal matters, and finally, to bring about the adoption of a code of ethics for the guidance of members of the respective professions in their dealings one with the other.

The addresses delivered at that meeting were published in the June 1956 issue of the Delaware State Medical Journal.

Your special committee on medico-legal cooperation was appointed by President Van Valkenburgh for the purpose of implementing the objectives mentioned herein.

Several joint meeting have been held by our committee and that representing the Delaware Bar Association. As a result of those meetings, the committee is of the opinion that we should continue our efforts, not only to bring the members of the medical and legal professions together so that we will in truth know one another, but also hold joint meetings so that the members of each profession will become familiar with the guiding principles of the other profession.

Accordingly your committee recommends that:

a. It be the policy of the Medical Society of Delaware to cultivate closer relations with the Delaware Bar Association.

b. That either the committee on Medical Services and Public Relations or a special committee on medico-legal cooperation be appointed to promote the objectives mentioned in this report by arranging for joint meetings of the medical and legal professions in each of the counties.

c. That the sum of $300.00 be appropriated to the use of the committee for actual expenditures necessary in the discharge of its mission.

d. The committee submits herewith a proposed code or guide for the conduct of the members of the Medical Society of Delaware and of the Delaware Bar Association.

Since this code or guide has been amended in some respects since it was distributed to the membership of our Society, your committee recommends that it be published in the Delaware State Medical Journal and that the Medical Council be authorized to adopt the code as an official publication of the Medical Society of Delaware unless the members express in writing to the President of the Society, their disapproval of such action—in which case, the President is requested to call a special meeting of the House of Delegates to consider the questions presented.

e. We wish to record our indebtedness to the Wisconsin State Medical Society and to the medical and legal professions of Cincinnati for their pioneer work in this field and upon which we have drawn heavily in the preparation of our proposed code or guide.

f. And finally, we wish to express our deep appreciation to those committee members of the Delaware Bar Association who participated in this project and, particularly to the Hon. Daniel L. Herrmann, Judge of the Superior Court of Delaware, without whose wise guidance and kindly enthusiasm, our efforts would have been infinitely more difficult.

Respectfully submitted,
J. LELAND FOX
PHILIP D. GORDY
WALTER H. LEE
J. STILES MCDANIEL, JR.
ROGER W. MURRY
MARTIN B. PENNINGTON
S. S. BJORNSON, *Committee Advisor*
VICTOR D. WASHBURN, *Chairman*

DR. WASHBURN: Mr. President, there are two points to which I would like to refer. One is that already we have adopted a budget appropriating $300. I would not presume to say how that came about, but it was accomplished. But the Committee has presented a suggestion, an alternative way. That proposal was that either the Committee on Public Relations, or the Medical Services and Public Relations, be assigned the task of carrying this out or that a special committee be appointed.

The basis of that recommendation was that when I was President of this Society we made an effort—in fact, in other administrations we have made an effort from time to time to limit the number of committees. We have a great many committees. The Committee therefore leaves to the judgment of the House of Delegates as to whether, first, will they accept the report and concur on its recommendations; and, secondly, will the House decide whether it shall go to an already existing committee or another special committee be appointed.

There is one other point, and that is this: We are submitting a proposed code of conduct. As a matter of fact, it is not only different from that which was distributed, and in some parts of that which was distributed it was illegible on one or two pages, but as a matter of fact even the subcommittee which has been working with the Bar Association actually considered that even this report will bear some polishing. And this proposal that we submitted and that it be published allows the Committee a little more time to shine it up before it is actually agreed upon and distributed for the action of the Society.

That is why we are proposing it as it is, that the members of the Society be given the privilege of studying the proposed document before it is actually adopted, and that the authority then be vested in the Council to adopt it if that appears that it has then met with the approval of the Society.

PRESIDENT VAN VALKENBURGH: Do I understand that the report is to be printed in the Journal?

DR. WASHBURN: Yes.

PRESIDENT VAN VALKENBURGH: Of the proposed code, is to be printed in the Journal, and then the members are to either write approval or, if they have any criticism——

DR. WASHBURN: Silence gives consent. If there are enough of those who feel that it is not correct, then of course the Council will not adopt it.

PRESIDENT VAN VALKENBURGH: The Council has discussed this matter, Dr. Washburn, as you know.

DR. WASHBURN: So that the first matter is, does the House accept the report? And secondly, does the House delegate it to an existing committee or to a new one?

PRESIDENT VAN VALKENBURGH: Thank you very much.

FROM THE FLOOR: I move the acceptance of this report.

(The motion was seconded.)

PRESIDENT VAN VALKENBURGH: With the recommendations?

FROM THE FLOOR: With the recommendations.

PRESIDENT VAN VALKENBURGH: Is there discussion?

DR. CANNON: There is an area of question in the report regarding whether this recommendation shall include a separate committee or whether it shall be included in the Medical Services Committee, and on that regard I would like to say something.

It would seem to me that the work of this Committee is extremely important and the Medical Services Committee is a busy committee. Would it not be advisable to continue the Medico-Legal Committee as a separate committee until the major part of the work of that Committee has been completed, and then perhaps as time goes on the Medico-Legal Committee can be incorporated in the Medical Services Committee as a sub-committee rather than a separate committee after the intensive character of its work has been completed. So that I think it should be a separate committee now, and later perhaps be absorbed in the Medical Services Committee.

PRESIDENT VAN VALKENBURGH: Is there discussion of Dr. Cannon's proposal?

DR. MURRAY: Mr. President, Dr. Cannon's proposal makes sense. We had a total of 13 letters from lawyers raising objections to portions of this code, and some of them were quite lengthy. Now, for the code to be of any real value, it has to be approved by the Bar Association as well as the Medical Association. It seems to me that the present committee ought to continue until this work of getting the code in final form and approved by both the Medical Society and the Bar Association is completed. I think that is the way it ought to be done.

After that—I thoroughly agree that we have too many committees, and after that work is done, then I think the committee could well be disbanded.

PRESIDENT VAN VALKENBURGH: Is there any other discussion?

DR. WASHBURN: Has the motion been seconded?

PRESIDENT VAN VALKENBURGH: Yes, it has been seconded.

DR. WASHBURN: Then that motion was to accept.

DR. CANNON: With an amendment.

PRESIDENT VAN VALKENBURGH: To accept the report, with an amendment. Those in favor of accepting Dr. Washburn's report will please say "aye".

(The motion to accept the report of the Medico-Legal Committee was carried.)

PRESIDENT VAN VALKENBURGH: Does that mean the continuation of the present Committee?

DR. CANNON: That is up to you.

PRESIDENT VAN VALKENBURGH: All right. There is a separate committee now. Is it necessary to make a separate motion?

DR. LEVY: Mr. Chairman, just to clear the record, I, too, agree with the previous speakers, Norm Cannon and Roger Murray that the present Committee should be a separate and distinct committee, and I move therefore that we continue with a distinct and separate committee as has been active in the past year. I move that that

committee be a special committee at the present time.

(The motion was seconded.)

PRESIDENT VAN VALKENBURGH: It has been moved and seconded that the present committee be a special committee.

DR. WASHBURN: That the committee be continued. Then you can appoint anyone you like.

PRESIDENT VAN VALKENBURGH: That the committee be continued. Those in favor say "aye".

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: We will now have the report of the Committee on Nominations.

July 30, 1956

The Nominating Committee, appointed by Dr. Van Valkenburgh, respectively submits to the Council and to the House of Delegates, the following nominations for the year 1957 as follows:

Vice-President ..... Dr. Oscar N. Stern
Treasurer ..... Dr. Charles Levy
Secretary ..... Dr. Norman L. Cannon
Delegate to the A.M.A. ... Dr. H. Thomas McGuire
Alternate Delegate ..... Dr. Leslie M. Dobson
Representative to the Delaware Academy of Medicine ..... Dr. Victor D. Washburn
Committee on Scientific Work ..... Dr. Norman L. Cannon
Dr. J. R. Elliott
Dr. James F. Flanders
Committee on Medical Education ..... Dr. Lewis B. Flinn
Dr. Lawrence L. Fitchett
Dr. G. B. Heckler
Committee on Public Laws ... Dr. J. Robert Fox
Dr. Daniel J. Preston
Dr. J. S. McDaniel, Sr.
Dr. W. O. LaMotte, Jr.
Dr. James Beebe, Jr.
Committee on the Budget ..... Dr. Charles Levy
Dr. M. A. Tarumianz
Dr. Thomas H. Pennock
Dr. Felix Mick
Dr. Harold J. Lagner
Committee on Publication ..... Dr. Clagett
Dr. Norman L. Cannon
Dr. M. A. Tarumianz

Respectfully submitted,

DR. LEWIS B. FLINN, *Chairman*
DR. C. L. MUNSON
DR. R. D. SANDERS
DR. R. R. LAYTON, JR.
DR. L. M. DOBSON
DR. J. L. FOX

DR. ALDEN: I move that the report be accepted as read.

(The motion was seconded.)

PRESIDENT VAN VALKENBURGH: It has been moved and seconded that the report be accepted as read and the nominations for officers be accepted. Those in favor give the usual sign.

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: The Secretary will cast the ballot.

(The Secretary cast the ballot for the election of officers.)

PRESIDENT VAN VALKENBURGH: At this time we will rise for a minute of silence while I read the names of those members who have died in the past year.

(The assembly then rose while President Van Valkenburgh read the names of the deceased members of the Society.)

PRESIDENT VAN VALKENBURGH: We have some resolutions on which we would like the action of the House of Delegates. Mr. Morris will read them.

MR. MORRIS: The first resolution comes from the Delaware State Dental Society, and it is with regard to fluoridation of community water supplies.

WHEREAS, the fluoridation of community water supplies has been demonstrated in three recently completed 10 year studies to reduce the incidence of dental decay among children by approximately 60%, and

WHEREAS, the complete safety of fluoridation has been repeatedly demonstrated in extensive scientific research, and

WHEREAS, fluoridation has been recommended and endorsed by all major national health organizations of the United States including the American Medical Association, the American Dental Association, the National Research Council, the Association of State and Territorial Health Officers and many others, and

WHEREAS, the community of Newark has already demonstrated that the fluoridation of the municipal water supply can be accomplished safely, efficiently, and inexpensively, be it therefore

RESOLVED, that the Medical Society of Delaware hereby reaffirms its endorsement and approval of fluoridation of community water supplies and urges that fluoridation be adopted in all communities in the State of Delaware as rapidly as local conditions will permit, and be it further

RESOLVED, that a copy of this resolution be forwarded to the Honorable J. Caleb Boggs, Governor of the State of Delaware; to Floyd I. Hudson, M.D., Executive Secretary of the Delaware State Board of Health; and to each community with a municipal water supply system.

PRESIDENT VAN VALKENBURGH: Is there a discussion on this resolution?

(No response.)

DR. BEEBE: I move that the resolution be adopted.

(The motion was seconded and carried approving the resolution of the Delaware State Dental Society.)

PRESIDENT VAN VALKENBURGH: We will now have the next resolution.

MR. MORRIS: This is a letter to the Medical Society of Delaware from Dr. Howard on behalf of the Pathology Society of the State of Delaware. I would like to submit the following information and recommendation for action by the House of Delegates. The letter is as follows:

September 6, 1956

During the last year the Pathology Society of the State of Delaware has been in communication with the State Board of Health regarding State Board of Health approval of laboratory tests run in non-physician supervised laboratories. This discussion arose following the State Board of Health's approval of a technician run private laboratory for the performance of Pre-marital Serology. The technician, although originally trained in an approved hospital school of technology, had his A.M.A. Registry Certification withdrawn when the Registry Board found that he was running a laboratory without the supervision of a licensed physician.

It was pointed out to the State Board of Health that once an unsupervised laboratory is approved, for one minor test, that often advertising is utilized to suggest that the organization has been approved for all types of tests.

In order to preserve the integrity and the ethical responsibilities of laboratory medicine, as prac-

ticed in the State of Delaware, the House of Delegates of the Medical Society of Delaware recommended to the State Board of Health that "State Board of Health approval for the performance of any laboratory procedure, being a part of the practice of medicine, be made only to a laboratory under the direction of a licensed physician."

As physicians we are not interested in interfering with the laboratory work of any lay technicians, but we do feel that State Board of Health approval should only be directed to those laboratories supervised by licensed physicians, who are, therefore, answerable to the Medical Society of Delaware and to the State Board of Medical Licensure.

Respectfully,

JOHN W. HOWARD, M.D.
President
Delaware State Pathological Society

DR. WASHBURN: May I ask a question through you, Mr. President?

PRESIDENT VAN VALKENBURGH: Yes.

DR. WASHBURN: Dr. Howard, did you discuss this matter with Floyd Hudson directly, in person, you or your committee, do you remember?

DR. HOWARD: The first invitation to discuss this matter has been to meet with the Board on the 28th of this month, but in the meantime there have been numerous discussions with the President of the Board and others and innumerable letters.

DR. WASHBURN: I may say, Mr. President, that I ask that question because I did discuss this matter with Floyd Hudson—I guess I have discussed it with you, that is, you and I have talked about it—and I talked to Floyd, and as I remember it, his defense was that it was a matter that involved Federal funds, or Federal regulations, and that he really did not have in his power to refrain from approving them. But if you are going to discuss it, that matter will be brought up in the future.

DR. HOWARD: That was never presented to us in the form of any letter. I have letters from Dr. Hudson and he just interprets the Delaware law which gives the Board of Health complete authority to approve. In other words, the Board of Health approves it.

DR. WASHBURN: I do not say dogmatically he made such a statement. That is just my recollection. If you are going to have a meeting, that answers it.

DR. ALDEN: I move the adoption of this resolution.

(The motion was seconded and carried to adopt the resolution presented by Dr. Howard.)

DR. CANNON: Now, there were certain changes in the by-laws by the Council, and this requires action by the House of Delegates at two meetings, which poses a problem because this is the only meeting of the House of Delegates, and it was thought that possibly a second reading could be had just prior to the election of a President tomorrow if enough members of the House of Delegates or the Society are present, and I think that would be consistent with the by-laws.

The first change recommended by the Council to the House of Delegates was that the by-laws be amended to permit the immediate past President of the State Society and the President-elect to be ex-officio members of the Council.

That is the first one.

PRESIDENT VAN VALKENBURGH: Suppose we take them one at a time. Is there a discussion on that proposed change in the by-laws?

(No response.)

PRESIDENT VAN VALKENBURGH: Is there a motion to adopt the change in the by-laws as read by Dr. Cannon?

DR. MARVIL: I so move that it be adopted.

DR. WASHBURN: Mr. President, if you will excuse me. The procedure is, the House of Delegates may amend these by-laws at any annual session by unanimous consent provided the motion or resolution to amend was introduced the day before the amendment was adopted, and provided further that at least 25 members of the House are present and voting when the amendment is adopted.

So you talk about it tonight, and if you have got 25 people tomorrow, you put it across.

PRESIDENT VAN VALKENBURGH: Well, I didn't know whether it had to be approved twice or not.

DR. WASHBURN: No. You propose it at this time.

PRESIDENT VAN VALKENBURGH: Very well. That is one proposal.

DR. CANNON: The second one: The Council recommends that the by-laws be changed with regard to its fiscal policy allowing for the payment of half of the annual dues for those members whose membership begins July 1. This will conform to County and AMA dues arrangements and represents a change from the April 30 date now in effect for the State Society.

The Council recommends that this change be adopted.

DR. WASHBURN: When you do bring it up, you are going to say such and such a section is amended by reading it?

DR. CANNON: We will have to find out which section it is.

PRESIDENT VAN VALKENBURGH: Is there another one?

DR. CANNON: Did we approve the Editorial Board?

PRESIDENT VAN VALKENBURGH: Yes, we did.

DR. CANNON: Then there is the matter of dependent medical care. May I speak on that for a minute?

PRESIDENT VAN VALKENBURGH: Yes, that should be brought up. I do not know how much time——

DR. CANNON: We are running late.

PRESIDENT VAN VALKENBURGH: We are running a little late.

DR. CANNON: Briefly, I went to a meeting in Chicago representing the Society on the implementation of the Dependents Medical Care Act which was signed into law this summer, and the State Society had no policy on this matter, and it involved three things.

One was that the State Society, or the County Societies—preferably the State Society—go on record approving a home-town type care program as called for under this law. This applies to dependents of men in the uniformed services. Having so approved such a program, the Society has to determine a fee schedule which will be acceptable to all the doctors taking care of these patients. This fee schedule is a fixed fee schedule, so-called service type contract. I don't like to use that word, but it means that the fee designated in the schedule represents the entire fee that will be paid for the services, and the doctor will not be permitted to charge additional fees for that same service.

These fee schedules have already been distributed to the counties and letters have been written, and it is hoped that the State Society will work out a uniform fee schedule for the entire State.

Thirdly, the State, preferably the State, has to designate a fiscal agent to handle the billing. The Department of Defense has designated the Army as the negotiating agent, but we will have to designate either the State Society, as in some States they have done, to act as a fiscal agent to handle the mechanics of billing, or Blue Shield, or an insurance agency to handle the matter of the billing.

Now, nothing can be done until a fee schedule is arranged and until we designate a fiscal agent, and it is imperative that it be done soon because the law is effective December 8 of this year.

So I think that first the House of Delegates should go on record as approving a home-town care program as called for by this law, and secondly possibly empower the Council to act for the House of Delegates when the fee schedules have been compiled by the county committees. And thirdly, either decide now which fiscal agent is desired by the State Society or submit to the recommendations of the Council after hearing from the County Societies.

The fiscal agent merely handles the billing, so that your bill would go into a designated agency which would send you a check, and the agency would charge the Government the amount paid to the doctor, plus a percentage for the mechanics, secretarial work, paper, and so forth.

PRESIDENT VAN VALKENBURGH: Is there a discussion of this?

DR. MCGUIRE: Mr. President, it would seem advisable for the Council under the guidance of the Secretary, who is apprised of what this law means, to make a recommendation after consultation with the County Societies.

PRESIDENT VAN VALKENBURGH: Well, of course, what we want to do is to empower the Council to act for the House of Delegates.

DR. MCGUIRE: That is what I so move, that the Council be so empowered.

(The motion was seconded.)

DR. CANNON: I would like to say, before any motion is passed, that it is important that all the doctors be satisfied that the action taken in terms of fees is satisfactory throughout the State because I cannot visualize any more touchy subject than fees, and I hope that the Council in working this thing out on a county level will satisfy everyone.

I want to put out also that these fees are subject to renegotiation annually with the Government.

DR. ALDEN: A question on this matter. I think this is done on a county-wide basis, the fee schedule, is that correct, Norman?

DR. CANNON: We are working it out on a county-wide basis, but it is desirable from the Department of Defense that it be state-wide because it is easier to handle if the fees are uniform, and of course we want the highest fees, not the lowest fees, and it should be easier to work out uniformly than if we had to work out the lowest fees.

DR. ALDEN: I wanted to emphasize that we have already done a little work on this in New Castle County. As a matter of fact, I think they are trying to have it completed by this coming Saturday. The radiologists in the northern end of the state met this past week and went through some ten pages of fee schedules and arrived at a mutually satisfactory figure. It was their intention to submit a copy of that to Dr. Dobson or Dr. McNinch for the two lower counties as a guide, or whatever they chose to do with it.

But I do want to emphasize that these figures that are listed are to be maximum figures. They are not necessarily the bill you will submit, but you must put a figure down that is maximum to cover all eventualities in any one of these cases.

DR. CANNON: Well, the Department of Defense also hopes that the fees will be reasonable.

DR. ALDEN: I did not mean to imply that they would be unreasonable, but the difficulty came up, especially in connection with radio therapy, where it is rather difficult to give charges that would cover any eventuality, because you are dealing with a number of modalities, they ask for figures which will cover treatment by x-rays, radium, radon, or any radio isotopes, you see, and that is to include the cost of the source.

So that the figure must be high enough that you will make out all right as far as a maximum is concerned.

In other words, if, say, it is a breast case that received external irradiation and would subsequently or during the same course receive some form of radio isotopes, maybe radio-active gold, something of that sort—so that it is important that the fee be high enough to cover the cost of such care.

DR. LEVY: It was our feeling in New Castle County—I might state that I appointed Les Whitney chairman of the New Castle County committee, and he and I had gone over a number of members of his committee, and they have been actively working on this fee schedule, and it was our hope that the lower counties would also have committee chairmen and men working on their fee schedules, and then the three counties should get together, either through their chairmen or a joint committee of the three counties, and that would represent our State Society fee schedule. I hope the lower counties will get to work on this fee schedule as promptly as possible.

PRESIDENT VAN VALKENBURGH: Well, Sussex County has a committee, and they are working on it. And I think your suggestion is very good for the three committees to meet and iron out the various differences in fee schedules.

MR. MORRIS: I might add that a meeting of that kind is planned for the last week of this month between the three county committees.

PRESIDENT VAN VALKENBURGH: Is there further discussion on this resolution, or do we have a question before the House?

DR. CANNON: There is a motion by Dr. McGuire that the Council be empowered to act for the House of Delegates in these three matters. I don't know who seconded it.

DR. BAILEY: I seconded it.

PRESIDENT VAN VALKENBURGH: Those in favor of this motion will say "aye".

(The motion was carried.)

DR. CANNON: The next item on the Council minutes had to do with authorization by the House of Delegates for the Executive Secretary to write checks for the payment of matters relative to the Journal fund. He is bonded to the extent of $10,000, I think I am correct, Dr. Tarumianz—am I correct?

DR. TARUMIANZ: Yes.

DR. CANNON: The House of Delegates has to authorize Mr. Morris to write checks.

DR. MCGUIRE: I move that that authority be given.

DR. TARUMIANZ: I second the motion.

PRESIDENT VAN VALKENBURGH: It has been moved and seconded that the authority be given to Mr. Morris to write checks.

DR. WASHBURN: That really will involve a resolution acceptable to the bank.

DR. TARUMIANZ: No, he is bonded. That is our responsibility.

DR. WASHBURN: But the bank will not accept his signature until a resolution is adopted by the authority concerned which authorizes it to present to the bank.

MR. MORRIS: The authority concerned I believe is the Publications Committee of this Society.

DR. TARUMIANZ: You are giving the authority to the committee?

PRESIDENT VAN VALKENBURGH: Yes.

DR. WASHBURN: All right.

PRESIDENT VAN VALKENBURGH: Giving authority to the committee to allow Mr. Morris to write checks on their funds.

The motion has been made and seconded. Those in favor say "aye".

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: What else do you have, Dr. Cannon?

DR. CANNON: We had that matter of Vocational Rehabilitation, to select a physician. Did we get anything from that?

PRESIDENT VAN VALKENBURGH: Dr. Stambaugh said that he had no one in the State of Delaware whom he wanted to propose or could propose as a candidate for that award.

DR. CANNON: Then I do not know of any further business, unless there is something from the floor.

DR. BEEBE: I have something to bring before the House of Delegates, and I think maybe Dr. Fox can add a little bit to it.

We have had considerable difficulty with the Medical Examiner and the Medical Examiner's law in Sussex County. I don't know whether this is the place to bring it up or not, but I would like to bring it before the House.

Apparently the Medical Examiner met with the Sussex County Medical Society at one time over in Milton last spring, and he told us about his problems, and during the discussion he brought out that he was not going to come down very frequently to do autopsies in this area, and we told him that particularly during the summertime we had a lot of accidents and drownings and things that many times should have autopsies performed upon them.

He in turn actually told us that he could not and would not do it, that he was the Medical Examiner mainly for Wilmington, and he had enough work to do there and was not going to come to Sussex County.

Well, we felt that he was honest in telling us that but we didn't like the remarks very much.

Now, on several occasions during the summer —on one occasion in particular, the State Police and the Coroner wanted an autopsy performed, and it was with considerable difficulty that they had to get him to come down and do the autopsy.

We realize that this is probably more than one man can handle and that his budget is limited, that probably the solution would be a deputy, or, even better than that, maybe he should have his office in Dover where he could go both ways, instead of going from one end to the other end. Possibly if he had his office in Dover, with a deputy in Wilmington, that might answer the question, or have a deputy at least in this area.

I don't know what the solution is, but I would like to hear some discussion of the matter.

DR. J. L. FOX (Seaford): I might add to that.

In the early spring we had very similar troubles in Seaford, as Dr. James Beebe spoke about. Patients would die, and the Medical Examiner would sign them out as a heart attack, or this and that, and it was in some cases very questionable to the family physician who had questioned the diagnosis. He felt that he was not able to make a diagnosis on these individual cases and he didn't see how the Medical Examiner, the assistant to the Medical Examiner, could make a diagnosis without autopsies.

The question came up at our Nanticoke Memorial Hospital staff meeting, and as secretary of the staff meeting I was instructed to write a letter to Dr. Bjornson and send copies of the letter to the Boards of post-mortem examiners and the Attorney General, who is authorized and in control of the Medical Examiner.

As a result of that letter Dr. Bjornson had a conference with the Board of Post-mortem Examiners and came down to Seaford to one of our staff meetings and discussed the whole situation with us.

At that time one of the things brought up was the possibility of authorizing a local pathologist to do autopsies on coroner's cases in which there was no legal question—for instance, deaths in the hospital within 24 hours, where there was no violence concerned; deaths of premature infants; and some of the things would probably not be worthwhile for Dr. Bjornson to come down and do the autopsy himself.

Since the conference that we had with Dr. Bjornson things have smoothed out very nicely in Seaford and we have been getting, as far as I know, every autopsy that any member of the staff has felt was necessary.

Another thing that Dr. Bjornson did, he invited two members from our staff, and I was under the impression that he would invite two members from every hospital staff in the State to attend a dinner meeting in Dover which was held some time in the middle of August. Dr. Moyer and I were invited, but we were both unable to attend. So I cannot give a report on that meeting. Perhaps someone else was there.

But at the present time in Seaford things are going very smoothly.

DR. BEEBE: One thing we have in Lewes that you don't have in Seaford, and not only Lewes but Milford and Dover, too, and that is that Dr. Pollack, our pathologist, is on the Board of Medical Examiners and therefore he says that he is not able to do autopsies that fall under the scope of the Medical Examiner because he is an employee of them, and for some reason or other in the law he cannot do it.

Secondly, he refuses to have anything to do with an autopsy of a hospital patient that has been admitted to the hospital and died under the Medical Examiner's law, whether they are hospital patients or not or whether he is authorized to do it or not.

So they are problems that we have that you do not apparently have with your pathologist from Salisbury. He is apparently not under that law.

DR. J. L. FOX: That was brought up by Dr. Bjornson, the difficulty of Dr. Pollack being on the Board and he could not employ himself. So they felt that they could not use Dr. Pollack as pathologist. That is one of the things that they had to iron out one way or another.

DR. HOWARD: I think perhaps I should do a little talking here as an impartial individual and as a pathologist.

I attended the meeting at the Dinner Bell and I am very unhappy that Jim Beebe was not there and Dr. Fox was not there.

I do not think there is actually any problem whatsoever, but I think there has been a whole-

sale dose of misunderstanding from the very beginning.

Yes, Dr. Pollack is on the Board, and the Board instructed him that in cases which bear directly on medico-legal problems, they would prefer that he not do the autopsy.

Now, the type of cases of direct medical-legal involvement are your murder cases, your litigation cases, and those Dr. Bjornson, at this meeting at the Dinner Bell—and to those of us who have been following this project through its growing pains, and it has had them—is more than willing to do. He has deputies also, and he has talked with Dr. Pollack, I believe—though I can only say secondhandedly.

Now, where the greatest problem of misunderstanding has arisen is the interpretation of what the coroner in the past should have done as an obligation and what the Medical-Legal Practice Act directs the Medical Examiner to have done.

From the time I came to Wilmington, and as in other hospitals outside the State and in Wilmington at the present time it has been the policy of the hospital to report to the Coroner first and, subsequently, as the Act was changed, to the Medical Examiner, those cases that fell under the Coroner's law, or under the Medical Examiner's law. The Coroner's law specifically stated that the Coroner should order an autopsy in all cases. The Coroner was layman. That law was not practiced to its fullest degree and, by mutual agreement, the fact that every case under the Coroner's Act was not posted was pretty well satisfactory to almost every physician in the State.

However, under the Coroner's Act a case that died that was a hospital case was autopsied in New Castle County by the hospital pathologist at no charge whatsoever to the Coroner's Office. That was not the case in Kent and Sussex. The Coroner ordered the cases done, and a pathologist was paid to do the cases for the Coroner's Office. In New Castle County cases outside the hospital that had medical-legal involvement that the Coroner wished to have done, numbering perhaps 1, 2 or 3 a year, were performed by pathologists on contract to the Coroner's Office, or by pathologists even from outside the State that were employed.

The Medical Examiner's Act does not tell or authorize the Medical Examiner that he must do an autopsy on any specific case. It tells him that he must to the best of his judgment protect the citizens of the State of Delaware from the perpetration of any crime; and he works with the Attorney General's Office in that regard.

At the present time in four hospitals in the City of Wilmington, the cases are reported to the Medical Examiner's Office, as indicated by the law. If the Medical Examiner chooses to take the case out of the hospital and autopsy it at any place or autopsy it with the use of the hospital facilities, he so indicates. If he tells the hospital that there is to his judgment from the investigation or the report of the physician reporting it no medical-legal implications, it then behooves the attending physician or his staff to obtain permission from the responsible people concerned in that case, and then the hospital pathologist performs the autopsy, sending a report to the Medical Examiner's Office to complete it.

If the Medical Examiner wishes to have a case done, he may then also request the pathologist at any one of the hospitals as a contract physician to work for him.

It would be physically impossible for your Medical Examiner to cover every case in the State. You all realize that. The important part is to iron out the system, help Dr. Bjornson obtain trained personnel in the immediate area to assist him on non-legal type of cases that fall under his jurisdiction, and constantly encourage the Post-mortem Board to gain additional funds so that we can have trained deputies and a toxicological laboratory and a bureau of investigation.

At the meeting at Dover—and there were several members here who can correct me if I am wrong—there was no dissension, no problem, and a very happy discussion among all concerned in regard to the problems of the Medical Examiner's Office.

Perhaps I have confused the issue, but I felt, having attended that meeting and being a pathologist, that I should speak.

PRESIDENT VAN VALKENBURGH: Is there any other discussion? Are there any recommendations by the members of the House?

(There was no response.)

PRESIDENT VAN VALKENBURGH: Dr. Fox, did you have anything to say at this time?

DR. FOX: No.

PRESIDENT VAN VALKENBURGH: Is there anything else?

DR. CANNON: I have nothing else.

MR. MORRIS: I would like to make one little suggestion before we adjourn, please.

Some of these exhibitors have been here in the hotel since 9 o'clock this morning, and they have yet to see their first physician. We are requesting on behalf of and for the good of the Society as a whole that everyone make it a special point to visit those exhibits today as well as tomorrow. Tomorrow will take care of itself. There will be a general meeting, more people here, but we very urgently request that you do look in on those exhibits before the next general meeting starts at 8:30. We would appreciate it very much. Thank you.

DR. MCGUIRE: One other comment on that, if I may, at the risk of being unpopular.

You will notice the number of detail men who call on you in comparison to the number of exhibitors here is terribly out of proportion, and I think it is incumbent upon us to make some remark to these detail men, why didn't you display at the Delaware Society meeting?

DR. WASHBURN: Now, there is a promoter.

DR. MCGUIRE: That is how we make money. We have too few exhibitors in comparison to the number of people who come here, only two or three of the major drug firms. There are quite a number of others who do not, and we at least owe these fellows something.

DR. BAILEY: I move we adjourn.

DR. J. R. FOX (Dover): Prior to adjournment, the group from Kent County would like to make some comments on the President-elect candidate at the present time.

DR. H. J. LAGGNER (Kent County): At the present time Kent County does not have a candidate for President-elect.

PRESIDENT VAN VALKENBURGH: Well, of course, that poses a problem so far as the by-laws are concerned. There has been mention a number of times that the State Society in their apportionment of Presidents, two to Wilmington, one to Kent and one to Sussex out of every four years, that New Castle County, with three-quarters of the doctors, is getting only half of the Presidents. So there has been some discussion about changing the rule, but I don't know whether there is any way in which we could elect a President-elect who is not from Kent County for the year in question. Dr. Tarumianz, do you know a way around that?

DR. TARUMIANZ: I am afraid not. The only suggestion I have is that some of our New Castle County medical members move into Kent County

and practice medicine there.

DR. LAGGNER: Kent County will forego its privilege of nominating this year and turn it back to the floor for nominations, or to the Nominating Committee, whichever would be in order.

PRESIDENT VAN VALKENBURGH: Well, I think we will have to think that one over and come up with an answer later unless someone has it now.

DR. WASHBURN: Mr. President, this has happened on other occasions. Counties have been a little bit dilatory in bringing in the name on the day the House met, but they always arranged to get together and bring one in surely by the next morning. Has Kent County actually voted not to present a candidate?

PRESIDENT VAN VALKENBURGH: So I have been told by the President of the County Society.

DR. WASHBURN: If that is official, all right.

PRESIDENT VAN VALKENBURGH: I have also been so informed by Dr. Fox, Dr. Laggner, Dr. Comegys and Dr. McNinch. I have discussed it with them at reasonably great length today. Previously I didn't know about it.

DR. TARUMIANZ: Mr. President, may I go back to the Medical Examiner question for a moment?

It behooves this House of Delegates to recommend to the Legislature to increase the appropriation for that particular office, thus allowing the Medical Examiner to have at least two deputies on salary, able to give service to the two lower counties, and other duties that he might perform.

Therefore I move that the House of Delegates pass a resolution in favor of increasing the budget of the Medical Examiner's Office to enable him to obtain the services of two additional deputies.

(The motion was seconded.)

PRESIDENT VAN VALKENBURGH: A motion has been made and seconded that we send a resolution to the Legislature——

DR. TARUMIANZ: To the President Pro Tem and Speaker of the House.

PRESIDENT VAN VALKENBURGH: All right.

DR. WASHBURN: Should it not go through our Legislative Committee, Dr. Tarumianz?

DR. TARUMIANZ: It would be wiser.

DR. WASHBURN: I would say so, that the Legislative Committee be so instructed.

DR. TARUMIANZ: To present this resolution to them.

PRESIDENT VAN VALKENBURGH: You agree on that change, Dr. Tarumianz?

DR. TARUMIANZ: Yes, sir.

PRESIDENT VAN VALKENBURGH: The motion has been made and seconded. Those in favor say "aye".

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: As to this other problem with regard to the President-elect, I think we will have to think it over and we will give an answer tomorrow, or later.

Is there any other business to come before the House of Delegates?

(There was no response.)

DR. BAILEY: I move we adjourn.

(The motion was seconded and carried and the House of Delegates of the Medical Society of Delaware adjourned.)

PRESIDENT VAN VALKENBURGH: Yesterday we had the first reading on some proposed changes in our by-laws and we will announce at the present time that we are going into the session of the House of Delegates. The House of Delegates is again in session. Do you want to see whether there is a quorum, Dr. Cannon?

DR. CANNON: I see a quorum.

PRESIDENT VAN VALKENBURGH: I will declare a quorum.

DR. CANNON: There were two motions read at the House of Delegates session yesterday regarding changes in the by-laws which requires two readings, one concerning the composition of the Council which, according to the present by-laws, shall consist of the Councilors elected by the component societies, President, Secretary and Treasurer, and it was moved—it was recommended by the Council that this motion and change in the by-laws be as follows: That the Council shall be composed of the Councilors, officers and the past President and the President-elect. This was designed in order to provide more continuity in the Council, and it is recommended that this change be adopted by motion of this House of Delegates.

PRESIDENT VAN VALKENBURGH: Are there any questions?

(There was no response.)

PRESIDENT VAN VALKENBURGH: You heard the motion. Those in favor please say "aye".

(The motion for the change in the by-laws was carried.)

DR. CANNON: The second motion to change the by-laws has to do with dues for half-yearly payment of those members who join the Society late in the year. The by-laws now say that the dues of a physician newly elected to active membership in a component Society after April 30 shall, for the year of his election, be one-half of the annual dues for a member of his class.

In order to conform with AMA and county dates, the motion has been made to change the by-laws so that this date will be July 1 for half-payment of dues, and the Council so recommends.

PRESIDENT VAN VALKENBURGH: You have heard the reading of the proposed change in the by-laws. Those in favor of the motion please state by saying "aye.".

(The motion was carried.)

DR. CANNON: I have two small matters which I would like to take care of.

First, I would like to introduce Mr. Larry Morris, our Executive Secretary, if you will just stand up so they can all see who you are. (Applause)

DR. CANNON: I also have been asked to announce that because of the lateness of the morning session, the luncheon has been moved up to quarter of 2, which means that we will probably start our afternoon session a little late and we will have to keep things rolling.

I have no other business.

PRESIDENT VAN VALKENBURGH: Is there any further business?

DR. FLINN: Dr. Van Valkenburgh, I would like to move that the Delaware State Society donate to the Delaware Academy of Medicine $1,000 per year, payable either annually, semi-annually, or quarterly.

(The motion was seconded.)

PRESIDENT VAN VALKENBURGH: It has been moved and seconded that the Medical Society of Delaware pay to the Delaware Academy of Medicine $1,000 per year. Is there any discussion?

DR. SHANDS: I would like to say, as President of the Academy, that this year our expenses are going to be much heavier than before, as we are starting now plans for a new building. We are going to need every dollar we can raise, I am sure, to do anything about this new building, and this appropriation at this time is certainly very much in order.

We hope, we of the Executive Committee that the Society will grant this sum.

DR. FLINN: Mr. Chairman, I would like to call attention to this Society that the Academy of Medicine has through its history been closely associated with the Medical Society of Delaware,

and that from the first there has been a designated member of this Society sitting on the Executive Committee of the Academy, and that the Academy's main function is to promote medical education through medical channels and through the public, and that the activities have been considerably augmented in the last several years and that the tempo has been increased in the last year or two in both the professional and lay fields.

The Council has already expressed a desire that as soon as practicable the main office of the Society, of the Medical Society of Delaware, will be in the building of the Academy of Medicine. And within the last year the activities of the Academy have been particularly extended beyond the confines of Wilmington and throughout the whole State.

Therefore it is of vital interest, I feel, having had some experience in both organizations, that this Society take at least this opportunity to show its support and appreciation and cooperation with the Academy of Medicine.

PRESIDENT VAN VALKENBURGH: Thank you, Dr. Flinn. Does anyone else have any discussion in regard to this matter?

(There was no response.)

PRESIDENT VAN VALKENBURGH: The motion as stated was that the Medical Society of Delaware appropriate $1,000 each year beginning with 1957. What was it the last time, $500?

DR. CANNON: Last year it was $500.

PRESIDENT VAN VALKENBURGH: Was that for '55?

DR. CANNON: It was moved in '55 and appropriated for '56.

PRESIDENT VAN VALKENBURGH: Appropriated for '56. Now, you have heard the motion. Those in favor of the motion will please denote by the usual voting sign by saying "aye".

(The motion was carried.)

PRESIDENT VAN VALKENBURGH: The "ayes" have it. It was not put in our budget when it was made up, but the motion has been made and carried that the Society donate $1,000 each year to the Delaware Academy of Medicine.

Is there any other business to come before the House of Delegates?

DR. CANNON: No, sir. We have no other business.

PRESIDENT VAN VALKENBURGH: Is there a motion to adjourn the House of Delegates?

(A motion was made, seconded and carried that the session of the House of Delegates be adjourned.)

PRESIDENT VAN VALKENBURGH: The next order of business is the election of a President-elect for 1957. This member is to come from Kent County.

DR. SMITH: (Kent County): President Van Valkenburgh, members of the Medical Society of Delaware, and guests:

I rise at this time to place in nomination for the office of President-elect of the Medical Society of Delaware for the year 1957 the Kent County selection, as we have selected this year for your approval a resident of the City of Milford. He has been in practice there for some 24 years. He has done an outstanding job. He is a capable physician. He served his community well. He is an active church member, he has served on the State Board of Health. He has shouldered his load down at the hospital in taking the clinic work and working in the Pediatrics Department, and I think in passing we should say that a large measure of the success of the Pediatrics Department and the Nursery Department at the hospital has been due to the untiring efforts of Dr. Baker in getting behind and pushing the newer procedures.

I would like to say also that he keeps up with his post-graduate work, he attends the medical conventions, and he is a member of the AMA and all the component societies.

So at this time the Kent County Society takes a great deal of humble pleasure in presenting for the Medical Society's action the name of Dr. John B. Baker of Milford.

PRESIDENT VAN VALKENBURGH: Thank you, Dr. Smith. Dr. Baker has been nominated.

DR. MCCOLLUM: Mr. President, I move the nominations be closed.

DR. BAILEY: I second the motion.

DR. POLLACK: Mr. President, I take privilege and pleasure in seconding the nomination of Dr. Baker.

PRESIDENT VAN VALKENBURGH: It has been moved and seconded that the nominations be closed.

If there are no other nominations, I will declare the nominations closed, and the Secretary will cast a ballot for Dr. Baker.

DR. CANNON: I will do so, Mr. President.

PRESIDENT VAN VALKENBURGH: Dr. Baker, do you care to come forward and say a few words or just from where you are if it is difficult to get up here?

DR. JOHN B. BAKER: I have a new bridge and am having trouble crossing it. (Laughter)

I thank you very much, and I will do the best I can, and if the bridge will permit me, I will cross this one. (Applause)

PRESIDENT VAN VALKENBURGH: A motion is now in order for adjournment.

(A motion was made, seconded and carried for adjourning the session.)

(At this point the convention adjourned until 2:30 o'clock, p.m., September 14, 1956.)

CHANGE IN ANNOUNCED SCHEDULE

The Wilmington General Hospital Scheduled Surgical Conferences have been changed from the first and third Saturdays to the first and third Wednesdays.

The Hospital's Journal Club meets on the first Saturday at 10:00 a.m. in the board room.

THAT 150,000-MEMBER CHECKUP

A conscientious car-owner takes his auto in for an occasional over-haul. He knows that even though repairs may be minor, amounting merely to a motor tune-up, removal of a "knock," or spark plug replacements, regular attention improves his car's performance over a long period of time.

A nationwide survey of physicians, commissioned by AMA, shows that medical organizations, too, can profit by similar internal inspections. Difficulties may be minor, but according to some physicians, medical organizations aren't hitting an all cylinders.

FAULTY TRANSMISSION?

Medical organizations must give increased attention to the problems of boosting meeting attendance and devote more efforts to drawing all members into active society

participation. Individual physicians need more information about actual benefits of membership as well as about policies and projects of their medical organizations. Too many physicians apparently don't know the facts about their own organizations.

Survey findings brought the need for attention to some of these problems into sharper focus. For example, only half of the physicians in this country report they are active in county and state organizations. One doctor in four says he didn't vote in his local society's last election. More than a third say they belong only to medical specialty groups not associated with AMA, or that they are more active in these other organizations.

Furthermore, about half of the doctors think of county and state societies as being different from AMA, when in reality these organizations compose the national association. Additional break-downs in the lines of communications between individual members and their organizations show up in misunderstandings about medical policies and lack of knowledge about organizational activities and services. A typical misconception has to do with dues; only half of AMA members actually know what national dues are and most doctors overestimate rather than underestimate dues.

It's encouraging to find that 90% of doctors in private practice report they are members of the AMA. More than half of the AMA members surveyed reported they belong to the Association because it's customary, it's the doctors' organization, or they believe in its policies. Yet 15% say membership is necessary for hospital affiliation or that it's compulsory. Informed physicians know that hospitals, not medical societies, determine rules and regulations for securing hospital privileges. And no physician is forced to associate himself with any medical organizations; if he joins, he does so voluntarily.

Many doctors cite AMA services or activities which they like, such as the Journal, meetings and conventions, information and exchange of ideas, and legislative action. But others say the Association is not representative, criticize it for being remote and uninterested in the individual physician and complain about its conservatism. Consequently, about a fifth of the members say they do not get value received for their AMA dues.

Although survey questions asked only about physicians' opinions in regard to AMA services, activities and policies, similar criticism would no doubt have been given had doctors been asked their opinion about their state associations. All along the organizational line, it's apparent that a better informational job needs to be done. The aid of state and county groups is needed to help sell physicians on the merits of cooperative action through medical organizations. For when a physician criticizes AMA, he is actually criticizing his local society and his state association, too. When his society joins in the complaining, the breech within the rank widens.

In the minds of some medical men a mythical "giant" has been built up in AMA. Newspapers have contributed to this illusory creation. AMA *is* an influential organization and since it comprises the greatest percentage of physicians in this country, it rightly claims title of official spokesman for the profession. Yet over the years critics of organized medicine have chisled a psychological rift by saying, "You individual MDs are ok and you're doing a good job—but AMA off in Chicago or Washington is the villian!" In reality, the individual physician is AMA. Repetition of this idea has made it harder—or less desirable—for an individual physician to identify himself with AMA.

This insidious dissociation process may be a contributing factor to the splintering off into smaller specialty groups which has been becoming more widespread in the past few years. Unaffiliated organizations are less controversial; with one or two exceptions they have received far less attention in the public press. When physicians who said they were more active in these specialty groups were asked why, they gave these replies: my specialty; local, closer; more interesting; smaller, more social; more worthwhile; easier to get to meetings. One clue for alert societies aiming at greater member participation was given in the response

by some doctors that "there's nothing to do in A.M.A."

Although the scientific programs of specialty groups will always hold appeal for numbers of physicians, the danger lies in the tendency of such organizations to begin speaking out separately on non-scientific matters affecting medicine. When many organizations begin professing to speak for medicine, the public becomes confused and the over-all impression is given that the members of the medical profession can't agree among themselves. Nobody denies the right of members to criticize their own organizations or to disagree with their actions; yet there are times when it is vital for medicine to present a united front. Those who believe in democracy accept the premise that the opinions of the majority should prevail—until the minority can change the opinions of that majority.

BATTERY NEEDS RECHARGING

The links in the chain of medical organization are the county and state associations. When poor attendance weakens their effectiveness, the collective strength of the entire profession is diminished. According to the survey, 50% of the doctors attend most meetings of their local or county society. Yet 6% say they attend no meetings, 16% very few, 9% some and 9% half. The problem of meeting attendance appears to be greatest in the East, where only 38% of the doctors say they attend most meetings. Western states evidentally chalk up the greatest attendance since 61% of the doctors say they turn out for meetings. Central and Southern states fall midway between, with 54% in the Midwest and 56% in the South attending most meetings. One or two other interesting sidelights were revealed in the study. For example, internists least often say they attend county meetings. Only 35% of the internists say they attend most meetings as contrasted with an average of 50% of all other types of doctors. Internists also least often say they voted in the society's last election of officers.

Doctors in the East least often believe they get their money's worth in return for dues (32% as against an average of 23%). Here again internists reflect a less favorable attitude toward medical organizations than other doctors. Twenty-six percent of the internists feel full value is not received in return for dues while general practitioners least often express dissatisfaction on this count (21%).

Another revealing discovery is that doctors rate the American Dental Association higher in terms of favorable impressions than they do their own medical organizations. About three out of four doctors say their impressions of both AMA and the ADA are all good or more good than bad. Yet, one doctor in twelve says he has negative impressions of AMA while only one in 50 is critical of the dental association. Doctors rank the American Bar Association in third place.

Time after time in the study the individual physician proved to be far more critical of his colleagues and of medical organizations than the public. For example, 24% of the doctors say the public looks upon AMA as a doctors' union and medical trust. Yet, this survey shows only 37% of the public has this opinion. During the past few years, the medical profession has worked hard to regain the confidence and good will of the public. Now it's obvious that some concentrated internal public relations efforts are necessary in order to rekindle physicians' enthusiasm and interest in medical organizations. Larger numbers of physicians ought to be pulling their own weight in their societies, rather than dragging their heels and allowing a few men to serve as standard bearers. Medical organizations must concentrate on doing a better job of informing their members about their activities, policies and services.

Physicians, in an effort to revamp their service programs for the public and to stave off a government medical program, have taken it on the chin from many critics. Most have accepted just criticisms humbly and moved ahead to correct sources of dissatisfaction. Perhaps it's time now to stop being on the defensive—to help physicians regain a sense of pride in the medical organizations to which they belong. An organization whose aims are "to promote the science and art of medicine and the betterment of public health" need not apologize for its efforts to advance these noble objectives.

Published in Philadelphia Medicine September 7, 1956.
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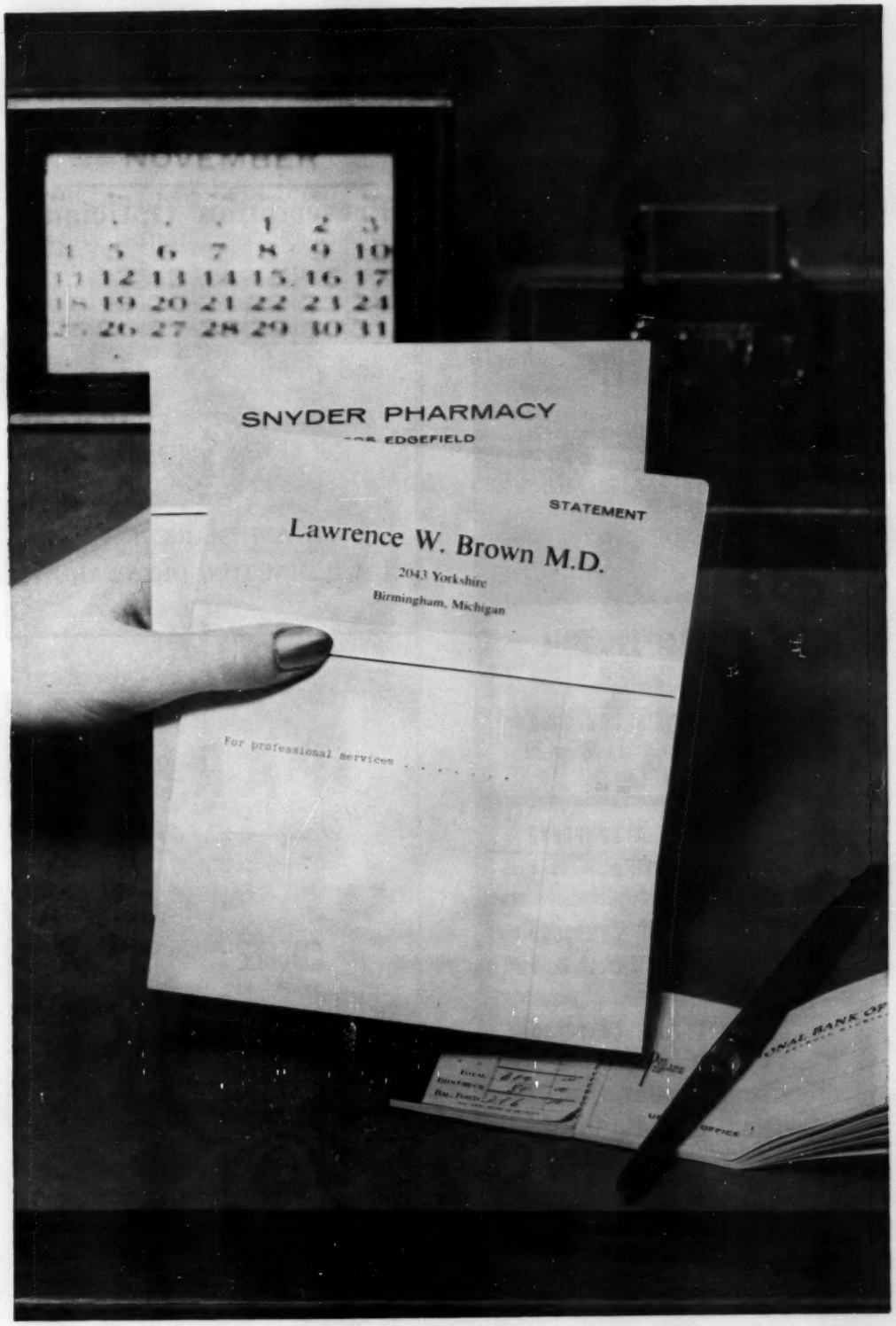
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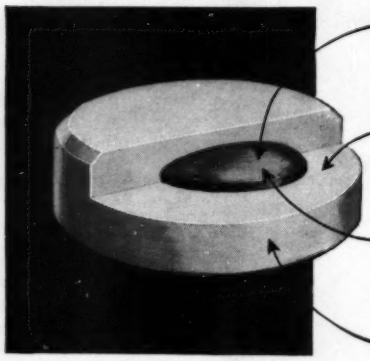

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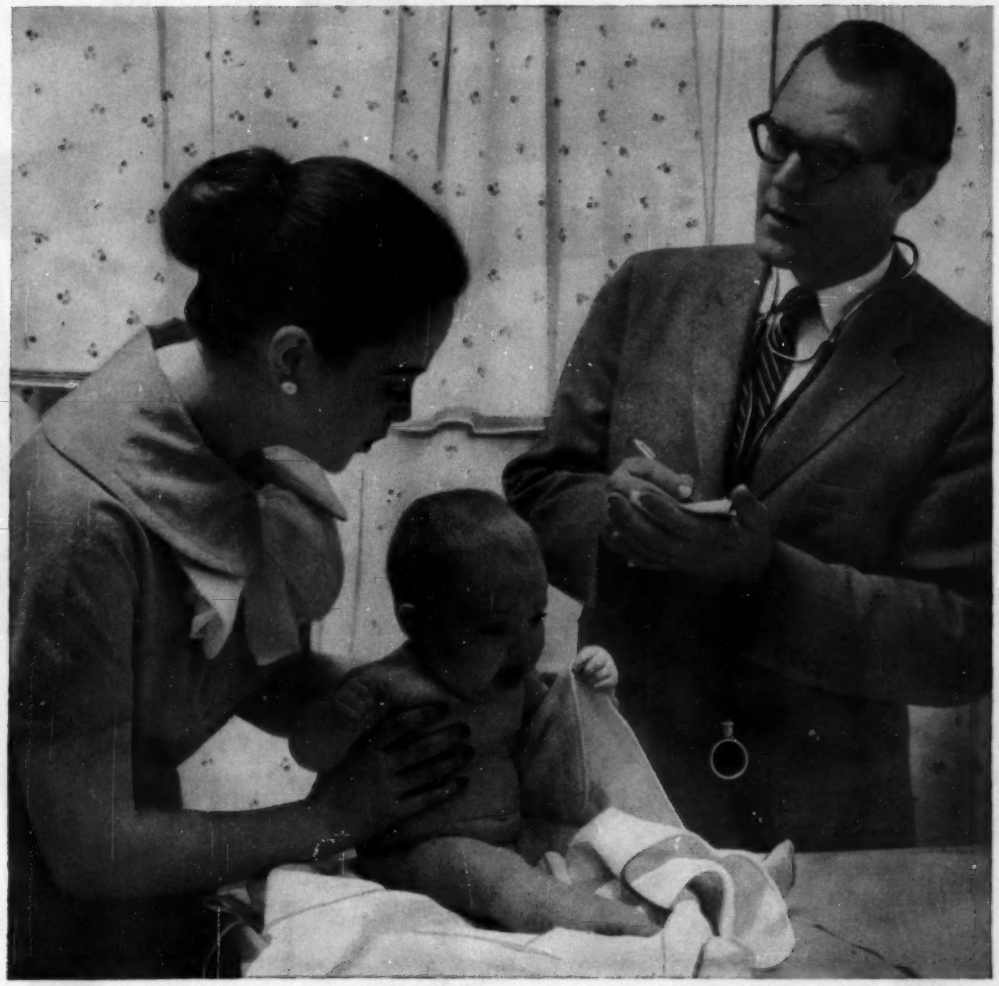

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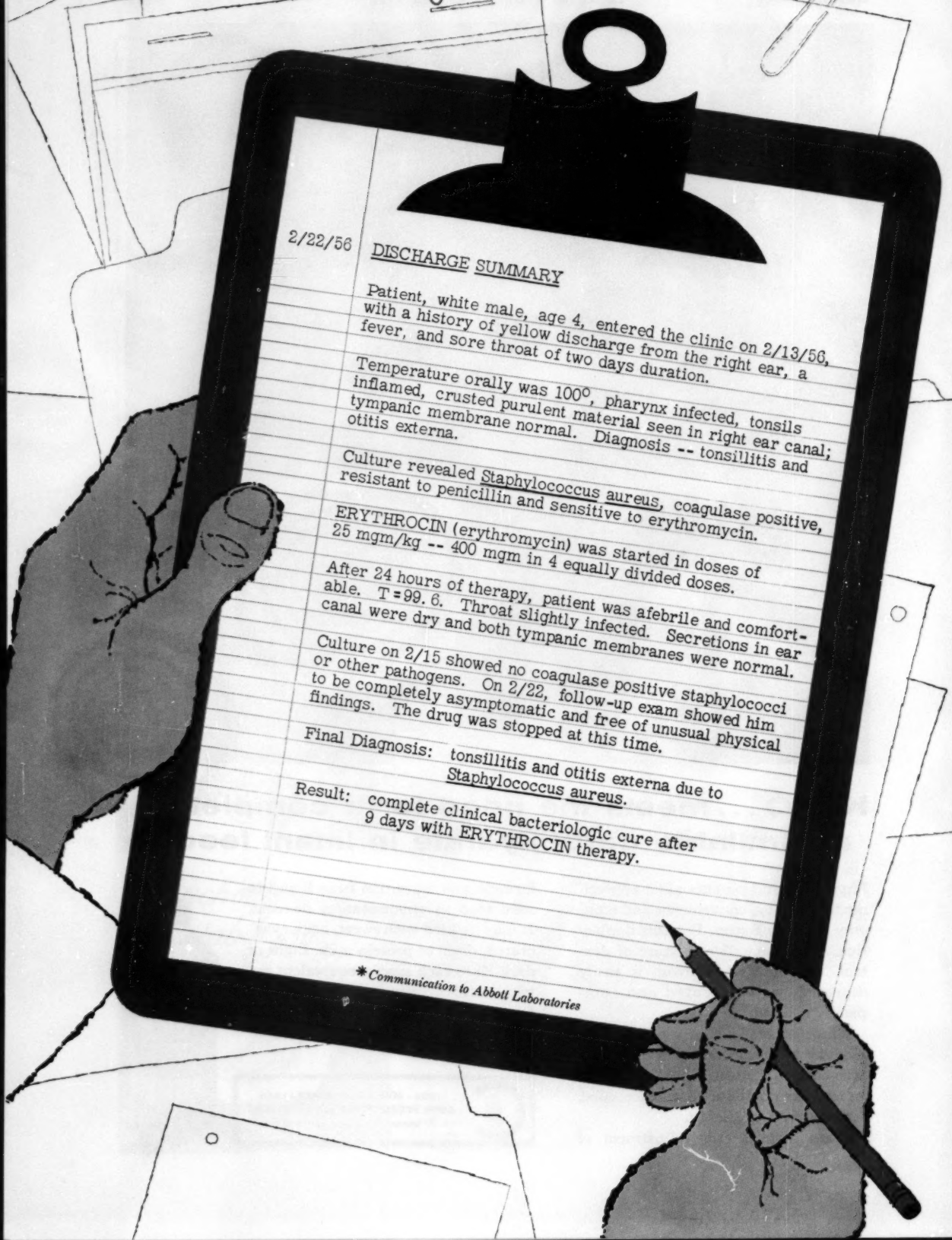
Erythrocin in treating tonsillitis and otitis externa*



2/22/56

DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, *"In all 18, the clinical response could be regarded as either good or excellent."*[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: *". . . the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients."*[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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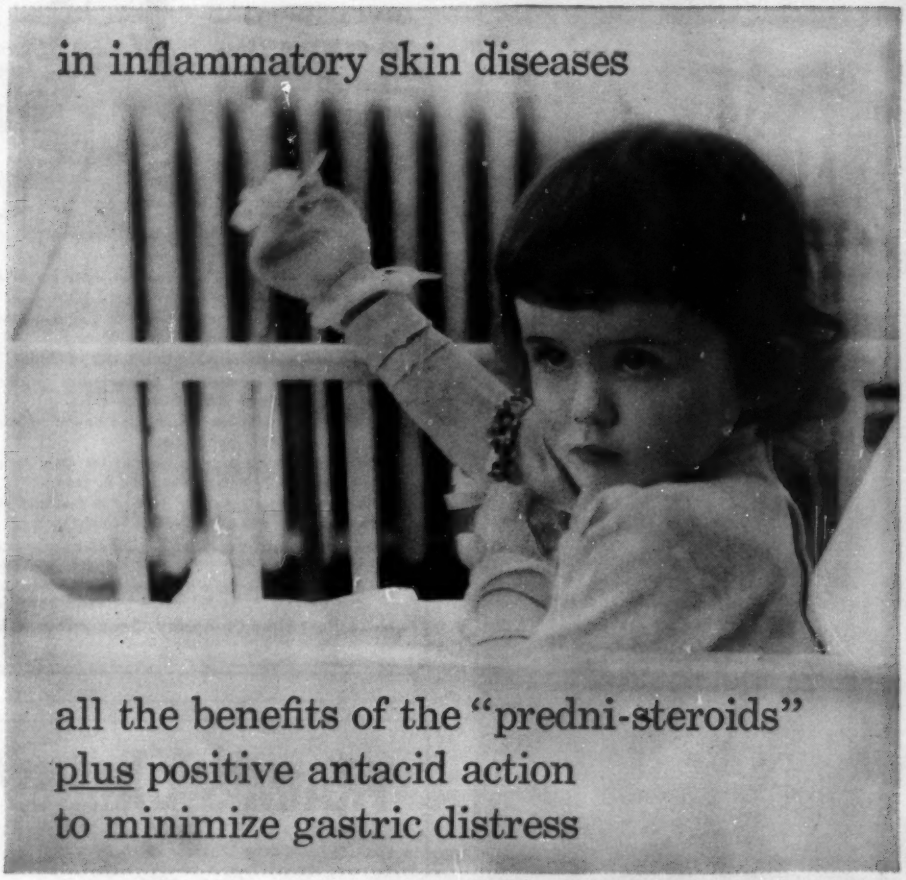

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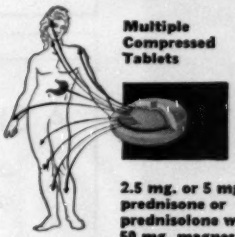

'Co-Hydeltra'
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2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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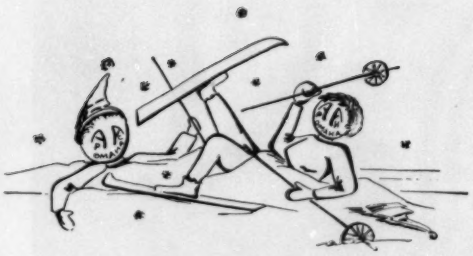

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